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THE UNIVERSITY OF ALBERTA

A COMPARISON OF ALBERTA, BRITISH COLUMBIA, AND ONTARIO INDUSTRIAL RELATIONS SYSTEMS IN THE HEALTH CARE INDUSTRY

by

© BARBARA C. VOIGT

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND
RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENT
FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION

FACULTY OF BUSINESS ADMINISTRATION AND COMMERCE

EDMONTON, ALBERTA
FALL, 1976

THE UNIVERSITY OF ALBERTA
FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled A Comparison of Alberta, British Columbia, and Ontario Industrial Relations Systems in the Health Care Industry submitted by Barbara C. Voigt in partial fulfillment of the requirements for the degree of Master of Business Administration in Industrial Relations.

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Date Oct. 19, 1976

ABSTRACT

This thesis is a comparative analysis of three industrial relations systems in the health care industry - namely Alberta, British Columbia, and Ontario. The thesis explores two major question. First, what are the structural or organizational determinants affecting the manner in which employers in the health care industry organize for collective bargaining and which of these organizational structures and hence employers' organizations is most effective and efficient in its collective bargaining. The second question explores the applicability of the model which was used as the conceptual framework. Specifically, is the industrial relations model proposed by Syed Hameed useful for comparing the organizational structures in the health care industry?

Of the determinants affecting the manner in which employers in the health care industry organize for collective bargaining, it appears that union organization is the most influential factor although the attitude of the employers' organizations to the issue of conflicts of interest, that is a conflict in representing members in matters of labour relations and also in matters relating to health care policy and liaison with government, appears also to play a part. In evaluating the effectiveness and efficiency of the employers' organization, it was found in Alberta that a single employers' organization incurred the lowest cost to the employers measured according to selected monetary items in selected terms of agreement.

Both British Columbia and Ontario, with two employers' organizations, incurred higher costs to the employer measured against the same criteria. The author concludes that a single organization should provide both labour relations and other services for its members and further that the concept of volunteer involvement in negotiating teams be maintained and encouraged as a valuable means of communication and a real vehicle for meaningful participation. The author further concludes that the open systems theory offered by Hameed does indeed provide a useful tool for analysis of industrial relations systems and evaluation of the structures of employers' organizations.

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CHAPTER I

INTRODUCTION

For the past few years, attention has been drawn to the health care industry by relatively large wages being demanded by unions and being accepted by employers' organizations. The subject of this thesis is an examination of the industrial relations system in the health care industry in Alberta, British Columbia, and Ontario with emphasis on the employers' organization.

The early 1970's were years of "catch up" in union wages. Unions were demanding higher salaries and wages as the cost of living increased during these years. Union demands were being met by employers and the result was a "sky-rocketing" increase in the cost of health care. Employers' organizations were being frustrated in their attempts to hold back wages. There was a search by employers "for a better way" in which to conclude collective agreements. As a result, the three provinces under discussion independently undertook a variety of studies to examine their existing employers' organization structures and to make recommendations for the way in which employers should be organized so that their industrial relations were made more effective. The early 1970's was therefore a period of introspection for the employers' organizations in Alberta, British Columbia, and Ontario.

PURPOSE

Employers' organizations in Alberta, British Columbia, and Ontario health care industries exist to bargain collectively, on behalf of its members, with various unions and other organized labour groups. Each organization structure supporting health care industry collective bargaining in Alberta, British Columbia, and Ontario is unique. The health care industries in these provinces are however similar. It is the purpose of this thesis to examine two questions. The first question of concern is what are the structural or organizational determinants affecting the manner in which employers in the health care industry organize for collective bargaining i.e. what causes the employers' organizations in Alberta, British Columbia, and Ontario to be different from one another.

A mechanism to examine these organizational structures vis a vis their environment is provided by systems theory. A systems theory specifically directed to industrial relations has been proposed by Syed M.A. Hameed and will be used to compare the health care industrial relations systems in Alberta, British Columbia, and Ontario with emphasis on the employers' organizations.[1] The second question of concern arises from the application of the systems model to industrial relations in the health care industry.

[1] Syed M.A. Hameed, "Toward An Integrated Industrial Relations Theory", Canadian Industrial Relations, Butterworth and Co. (Canada) Ltd. Toronto, 1975.

SCOPE

The scope of this thesis is necessarily limited. First, emphasis is being placed upon the employers' organization in only three provinces. Second, the aspects for comparison and evaluation have been selected not only because they appear to be of importance to employers' organizations but also because of the relative difficulty in defining and measuring various criteria. The parameters for evaluation are cost to the employer as measured by selected terms in selected agreements, autonomy of the individual institution as a result of the collective bargaining process, and the number of strikes and man-days lost in the health care industry for selected years.

There are a great number of additional factors which could be used in comparing and evaluating health care industrial relations systems. For example, productivity of workers, the relative amount of work done or services performed as well as the quality of the work or service, is not discussed. The measurement of productivity in health care, although of interest to employers for years, has only recently received attention in terms of the development of measurement tools. Similarly, the cost of living in each province and in regions within each province are recognized as affecting collective bargaining and industrial relations but has been omitted because of the complexity of the factors which influence the final "real" wage.

LEGAL DEFINITIONS

Alberta

In each province the labour legislation defining the participants in collective bargaining is similar. The Alberta Labour Act, 1973 defined "collective bargaining" as "to negotiate with a view to the conclusion of a collective agreement or the revision or renewal of a collective agreement".[1] A "collective agreement" is defined to mean "an agreement in writing between an employer or an employers' organization and a bargaining agent, containing terms or conditions of employment".[2] "Employers' organization" and "bargaining agent" are defined to mean respectively "an organization of employers acting on behalf of an employer or employers, having as one of its objects the regulation of relations between employers and employees, whether or not the employers' organization is a registered employers' organization", and "a trade union acting on behalf of employees in collective agreement with an employer or employers' organization, whether or not the bargaining agent is a certified bargaining agent."[3] In Alberta "trade union" means "an organization of employees which has a written

1 Revised Statutes of Alberta, Alberta Labour Act, 1973 Chapter 33, February 1975, Page 22.

2 Ibid..

3. Ibid..

constitution, rules or by-laws and has as one of its objects the regulation of relation between employers and employees".[1]

British Columbia

The Labour Code of British Columbia has a similar definition but adds to the meaning of bargaining agent that an agent of an employers' organization must be accredited as such by the Labour Relations Board.[2]

Ontario

The Labour Relations Act of Ontario provides definitions similar to those in the Alberta Labour Act.[3] It includes a separate definition however for an "accredited employers' organization" which is accredited under the Act.[4]

OTHER DEFINITIONS

Nursing services includes paid hours for all non-medical staff

[1] Ibid..

[2] Revised Statutes of British Columbia, Labour Code of British Columbia, 1973, Chapter 122, December, 1974, Page 2097.

[3] Revised Statutes of Ontario, The Labour Relations Act, Chapter 232, March 1975, Page 3.

[4] Ibid., Page 4.

employed in nursing administration, in short and long-term nursing units, newborn nursery, delivery room, operating room, emergency units, central supply room, inhalation therapy, intravenous therapy, other nursing services and other services provided by the nursing department staff such as the organized out-patient department, special clinics and pharmacy.[1]

Special services includes paid hours for all non-medical staff employed in the organized out patient department (recognized by the Provincial Plan as formally organized), special clinics, laboratory, E.C.G. (E.K.G.), E.E.G., radioisotope services, physical medicine, radiology - diagnostic and theraputic and rehabilitation, social service, ambulance service, office of the medical staff (clerical and stenographic), special research projects and other services organized as separate units not falling into the preceding categories.[2]

Education services includes paid hours for all staff, i.e. medical interns and residents but not other medical staff, other instructors, school staff, and students of formally organized education programs, in medical education, nursing education, laboratory technologists training, radiology technicians training and other student formally organized training.[3]

[1] Statistics Canada, Hospital Statistics, Vol. III Hospital Personnel, Information Canada, Ottawa, 1972, Page 16.

[2] Ibid..

[3] Ibid..

General services includes paid hours for all non-medical staff employed in general administration, medical records and medical library, dietary, laundry, linen service, housekeeping, motor service (excluding ambulance), plant operation and hospital security, plant maintenance, ancillary operations and other general services not included above.[1]

Rated bed capacity means the number of beds and cribs which the hospital is designed to accommodate on the basis of established standards of floor area per bed as at December 31 of the reporting year.[2]

[1] Ibid..

[2] Ibid..

SOURCES OF DATA

The sources used in this thesis were major reports and studies concerning collective bargaining conducted by various organizations and interested parties in the health care industries of Alberta, British Columbia, and Ontario. In addition, the author attended a number of seminars and meetings and held informal discussions with management and union representatives which are listed in Appendix 1.

Statistical data which indicates the extent of unionism in the health care industry, e.g. either the total number of workers organized in the health care industry or the number of hospitals with union locals represented in the institution, are not gathered by any provincial or federal agency. Similarly, there are no published statistical data available indicating the number of strikes, conciliations, or mediations in the health care industry although unpublished data regarding strikes has been used.

FORMAT

The remainder of this chapter indicates the magnitude of the health care industry in terms of numbers of institutions, personnel employed, and gross salaries and wages.

Chapter II presents a conceptual framework within which the comparison of the provincial health care industries is made. Chapter III presents the characteristics affecting the bargaining process. Chapter IV compares the health care industries in Alberta, British Columbia, and Ontario with emphasis on the employers' organizations; and Chapter V evaluates the outputs of these organizations. Conclusions are presented in Chapter VI.

MAGNITUDE OF THE HEALTH CARE INDUSTRY

The provinces of Alberta, British Columbia, and Ontario have been chosen because each province has an established employers' organization. The Alberta Hospital Association, British Columbia Hospital Association, and the Ontario Hospital Association have all been involved in health care industrial relations for over ten years.[1] All three provinces have been relatively wealthy provinces and have been leaders in wages in the health care industry.

Each province is characterized by a health care industry in which the provincial government is the third party payer through a universal health care insurance program. In each province, a health care industry employers' organization exists to provide collective bargaining services to its member institutions. Each province also has various unions and professional associations representing health care workers. Nurses, general service workers, and technologists are all represented in collective bargaining by their own bargaining agents.

Bargaining in Alberta and British Columbia is essentially province-wide. Bargaining in Ontario has been fragmented with a few institutions cooperating in group negotiations while many others conduct negotiations independently. In 1976, partially as a result of

[1] Exact dates are difficult to determine, says Leo Lancaster of the Alberta Hospital Association, but all three provincial organizations began some form of collective bargaining during the early 1960's.

the Hospital Inquiry Commission Report of 1974, Ontario will experiment with pattern bargaining: i.e. negotiations will be conducted between the employers' organization and various bargaining agents for a few major hospitals in an attempt to conclude an agreement which would establish the pattern for agreements concluded by other institutions.[1] The environments however appear quite similar. Alberta, British Columbia, and Ontario are characterized as "have" provinces i.e. relatively wealthy. Politically, each province subscribes to the western democratic tradition albeit within this tradition there exists a variety of political parties. Legally, each province is subject to the same federal legislation and provincial legislation in health care has many similarities. Finally, the social structure in each province is characterized by an English speaking majority.

Table 1, at the end of Chapter I, illustrates for selected occupations the average monthly salary rate by province for the years 1970, 1971, 1972, and 1973 (the most recent figures which are available).[2] It can be seen from Table 1 that with few exceptions Alberta, British Columbia, and Ontario have been leaders in wages in nursing service, paramedical, and general service categories. The major

[1] Alden, R.E., et.al., Report of Hospital Inquiry Commission November, 1974, presented to the Minister of Labour, Ontario, November 8, 1974, Page 43.

[2] Labour Canada, Economics and Research, Wage Rates, Salaries, and Hours of Labour, Ottawa, 1970, 1971, 1972, 1973.

unions and professional associations, Canadian Union of Public Employees (C.U.P.E.) and registered nurses associations, are represented in each province.

The health care industry in the provinces of Alberta, British Columbia, and Ontario has a potential market of some 12.5 million people. Alberta's population is approximately 1.8 million people, all of whom could, at one time or another, be expected to be recipients of health services.[1] In Alberta, a total of 157 hospitals provide 15,147 beds, or approximately 8.5 beds per 1000 population. Similarly, British Columbia has 120 hospitals for a total of 16,241 beds, or 6.6 per 1000 population; and Ontario has 300 hospitals for a total of 53,077 beds, or 6.4 beds per 1000 population.[2]

Table 2, also at the end of this Chapter, details the types of hospitals and numbers of beds by province.

Table 3 indicates that in 1972, personnel employed by these hospitals numbered 22,328 full-time and 4,591 part-time in Alberta, some 22,784 full-time and 3,274 part-time employees in British Columbia, and some 100,557 full-time and 18,821 part-time employees in Ontario.[3]

1 Information Canada, Canadian Statistical Review, Ottawa, November, 1975, Section 2, Table 1, Page 20.

2 Statistics Canada, Hospital Indicators, Information Canada, Ottawa, January-March 1975, Statement 1, Page 16.

3 Statistics Canada, Hospital Statistics Volume III, Hospital Personnel 1972, Information Canada, Ottawa, Statement 1, Page 25.

Projecting these figures to the first quarter in 1975, this meant that Alberta had an average of 185 full-time personnel per 100 rated beds for general hospitals,[1] British Columbia had 159 full-time personnel per 100 rated beds for general hospitals, and Ontario had 192 full-time personnel per 100 rated beds for general hospitals.

Table 3 also shows that gross salaries and wages for 1972, according to Statistics Canada, amounted to approximately 70.1% of total operating expenses for all hospitals.[2] In Alberta during 1972, total operating expenses were approximately $212,000,000 of which salaries and wages were 70.1% or approximately $149,000,000.[3] Likewise, operating expenses in British Columbia and Ontario were about $245,000,000 and $1,000,000 respectively for 1972; and gross salaries and wages made up about $172,000,000 and $750,000,000 in British Columbia and Ontario respectively. This amounted to per capita operating expenses for all hospital of $128.19 in Alberta. $109.00 in British Columbia and $136.65 in Ontario.[4]

[1] Hospital Indicators, Op.cit., Table 147, Page 147.

[2] Statistics Canada, Hospital Statistics Volume VI Hospital Expenditures 1972, Information Canada, Ottawa, Statement 3, Page 21.

[3] Ibid., Statement 1, Page 21.

[4] Ibid., Statement 2, Page 22.

Table 4 indicates the number of full-time and part-time personnel by services at December 31, 1972. Patient care, or nursing services personnel, accounted for 39.8% or 10,720 full-time staff in Alberta, 42.8% or 11,154 full-time staff in British Columbia, and 38.6% or 45,633 full-time staff in Ontario. Total nursing services staff amounted to almost fifty percent of all staff in each province.

Table 5 details the percentage distribution of paid hours by type of service in each province. Patient care services are represented in Table 5 by nursing services which account for 51.2% of paid hours in Alberta, 49.5% of paid hours in British Columbia, and 49.4% of paid hours in Ontario. In each province for each patient care paid hour there is a paid hour for non-patient care services which includes special, education, and general services as defined in this Chapter.

The statistics indicate the magnitude of the task of collective bargaining in the health care industry in the provinces selected for this study. That is, over 172,000 full-time and part-time staff are employed and over one billion dollars in gross salaries and wages are paid. Although not all health care institutions are unionized and not all institutions are members of the employers' organizations, most institutions are either direct participants in collective bargaining or voluntarily adopt the terms of the negotiated agreement. Hence, the employers' organizations are significant as a major determinant of the cost of labour in the health care industry. It is therefore of interest to analyze and compare the health care industries and the

organization structures supporting collective bargaining in order to gain an appreciation of those structures which perform most effectively and efficiently.

Table 1 AVERAGE SALARY RATE PER MONTH FOR SELECTED OCCUPATIONS BY PROVINCE FOR 1970, 1971, 1972, 1973[1]

Staff Nurses

	1970	1971	1972	1973
B.C.	612	660	710	755
Alta.	545	585	618	662
Sask.	530	563	589	628
Man.	536	583	621	676
Ont.	560	606	650	700
P.Q.	541	575	-	680
N.B.	479	545	594	639
N.S.	494	545	578	615
P.E.I.	503	526	468	611
Nfld.	471	524	529	529

Certified Nursing Aide

	1970	1971	1972	1973
B.C.	445	495	528	568
Alta.	375	399	434	479
Sask.	363	378	425	500
Man.	375	395	430	486
Ont.	401	441	481	528
P.Q.	442	462	-	547
N.B.	313	406	423	459
N.S.	357	389	421	439
P.E.I.	331	358	383	438
Nfld.	314	356	388	441

[1] Labour Canada, Economics and Research, Wage Rates, Salaries and Hours of Labour, Ottawa, 1970, 1971, 1972, 1973.

Table 1 continued

General Service

Laundry Operator - Female

	1970	1971	1972	1973
B.C.	372	434	457	503
Alta.	336	363	388	420
Sask.	305	312	361	405
Man.	285	313	340	356
Ont.	327	365	394	422
P.Q.	345	362	-	431
N.B.	232	295	308	343
N.S.	262	302	325	351
P.E.I.	264	286	308	-
Nfld.	205	243	263	307

Stationery Engineer 4th Class

	1970	1971	1972	1973
B.C.	3.77	4.38	4.56	5.25
Alta.	3.42	-	2.95	3.79
Sask.	2.59	2.65	3.23	3.58
Man.	2.75	2.96	3.23	3.39
Ont.	3.10	3.40	3.59	3.83
P.Q.	2.81	2.86	-	3.35
N.B.	2.40	3.00	3.06	3.35
N.S.	2.34	2.70	2.99	3.17
P.E.I.	-	-	-	-
Nfld.	2.36	2.55	2.82	3.21

Hourly Wage Rate

Table 1 continued

Paramedical

Laboratory Technicians - Male

	1970	1971	1972	1973
B.C.	647	703	759	809
Alta.	565	579	603	666
Sask.	508	580	590	740
Man.	554	583	607	-
Ont.	549	609	650	707
P.Q.	524	575	-	673
N.B.	-	-	-	522
N.S.	509	567	596	636
P.E.I.	-	-	-	-
Nfld.	522	528	539	630

Laboratory Technicians - Female

	1970	1971	1972	1973
B.C.	553	584	630	709
Alta.	483	520	552	586
Sask.	456	482	512	567
Man.	438	495	532	-
Ont.	480	528	560	599
P.Q.	515	540	-	587
N.B.	395	478	482	518
N.S.	387	445	450	497
P.E.I.	407	422	438	-
Nfld.	399	421	429	462

Table 2 TYPES OF HOSPITALS AND NUMBER OF BEDS BY PROVINCE[1]

Type of Hospital	Alberta		British Columbia		Ontario	
	No.	Beds	No.	Beds	No.	Beds
Public:						
General non-teaching	111	5,320	85	8,550	171	29,377
General full-teaching	6	5,051	2	2,387	17	12,135
General partial teaching	1	513	4	21,148	3	1,530
Total General	118	10,884	91	13,085	191	43,042
Paediatric	1	128	1	83	2	1,088
Rehabiliation	1	385	5	654	6	567
Extended care	27	.2,656	11	1,011	23	4,854
Other	2	176	8	167	12	420
Total Public	149	14,229	116	15,000	234	49,971
Private	0	0	2	16	53	1,292
Federal	8	918	2	1,225	13	1,814
All Hospitals	157	15,147	120	16,241	300	53,077

[1] Statistics Canada, Hospital Indicators, Information Canada, Ottawa, January-March 1975, Statement 1, Page 16.

Table 3 PERSONNEL AND GROSS SALARIES AND WAGES BY PROVINCE[1]

	Alberta	British Columbia	Ontario
Full-time personnel	22,328	22,784	100,557
Part-time personnel	4,591	3,274	18,821
Total personnel	26,919	26,058	119,378
Total operating expenses	$ 212,148,000	$ 244,915,000	$ 1,069,300,000
Gross salaries and wages (70.1% of total operating expenses)	$ 148,715,748	$ 171,685,415	$ 749,579,300

[1] Statistics Canada, Hospital Statistics Volume III, Hospital Personnel 1972, Information Canada, Ottawa Statement 1, Page 25.

Statistics Canada estimates that for all provinces gross of salaries and wages represents 70.1% of total operating expenses.

Table 4 PERSONNEL EMPLOYED AT DECEMBER 31, 1972, BY SERVICE BY PROVINCE[1]

	Alberta		British Columbia		Ontario	
	Personnel	%	Personnel	%	Personnel	%
Nursing Service						
Full-time	10,720	39.8	11,154	42.8	45,633	38.6
Part-time	2,627	9.8	1,255	4.8	9,923	8.4
Total	13,347	49.6	12,409	47.6	55,556	47.0
Special Service						
Full-time	2,334	8.7	2,581	9.9	13,833	11.7
Part-time	385	1.4	380	1.5	1,917	1.6
Total	2,719	10.1	2,961	11.4	15,750	13.3
Educational Service						
Full-time	2,478	9.2	2,003	7.7	10,066	8.5
Part-time	38	.1	19	.1	237	.2
Total	2,516	9.3	2,022	7.8	10,303	8.7
General Service						
Full-time	6,789	25.2	7,039	27.0	30,324	25.6
Part-time	1,536	5.7	1,617	6.2	6,415	5.4
Total	8,325	30.9	8,656	33.2	36,739	31.0
Hospitals Reporting	183		118		302	
Total Personnel						
Full-time	22,321	82.9	22,777	87.4	99,856	84.4
Part-time	4,586	17.0	3,271	12.6	18,492	15.6
Total	26,907	99.9	26,048	100.0	118,348	100.0

[1] Statistics Canada, Hospital Statistic Volume III, Hospital Personnel, Information Canada, Ottawa, 1972, Page 36.

Table 5 PERCENTAGE DISTRIBUTION OF PAID HOURS DURING 1972 BY SERVICE FOR ALL HOSPITALS BY PROVINCE[1]

	Alberta	British Columbia	Ontario
Paid Hours			
Nursing Service	51.2%	49.5%	49.4%
Special Service	10.6%	11.2%	13.7%
Education Service	5.0%	5.6%	4.2%
General Service	33.1%	33.7%	32.8%
Total Number of Hospitals Reporting	152 (100%)	118 (100%)	272 (100%)

[1] Statistics Canada, Hospital Statistics Volume III, Hospital Personnel 1972, Information Canada, Table 2, Page 30.

CHAPTER II

CONCEPTUAL FRAMEWORK

It is the purpose of this chapter to define the conceptual framework within which industrial relations systems in the health care industries in Alberta, British Columbia, and Ontario will be compared and evaluated. The conceptual framework itself will be evaluated vis a vis its usefulness in analyzing different health care industrial relations systems. The framework to be used and evaluated is based on open general systems theory as proposed by Syed Hameed.

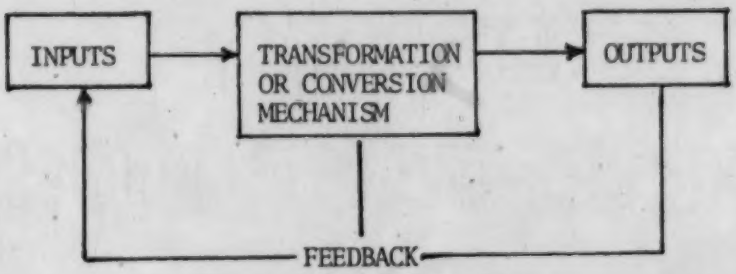
GENERAL SYSTEMS THEORY

General systems theory has been characterized by Kast and Rosenzweig as a basis for the unification of science,[1] and by Boulding as a skeleton of science.[2] A key concept of general theory is its open systems view. Open systems, as opposed to closed systems, exchange information and material with their environments e.g. biological and social systems. Closed systems do not exchange information or material with their environment e.g. some mechanical systems. The concepts of open and closed are not absolute but ends to a continuum. The open system is in a dynamic relationship with its environment. It receives inputs and transforms these into outputs. Information concerning the transformation process and outputs is fed back as inputs into the system. Diagram 1 illustrates the basic components and their relationships.

[1] Kast, F.E. and Rosenzweig, J.E., Organization and Management - A Systems Approach, McGraw-Hill, 1970.

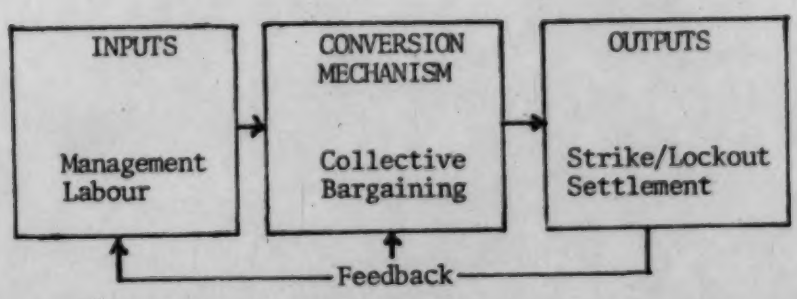
[2] Boulding, K.E., "General Systems Theory - the Skeleton of Science," Management Science, 2, 1956, Pages 197-208.

Diagram 1 BASIC COMPONENTS AND RELATIONSHIPS IN OPEN SYSTEMS THEORY



The process of collective bargaining, the transformation or conversion mechanism operating in the health care industry, is illustrated below in its most simple form where the interaction of labour and management in negotiations results in a labour agreement or other outcome such as a strike or lockout.

Diagram 2 PROCESS OF LABOUR MANAGEMENT COLLECTIVE BARGAINING

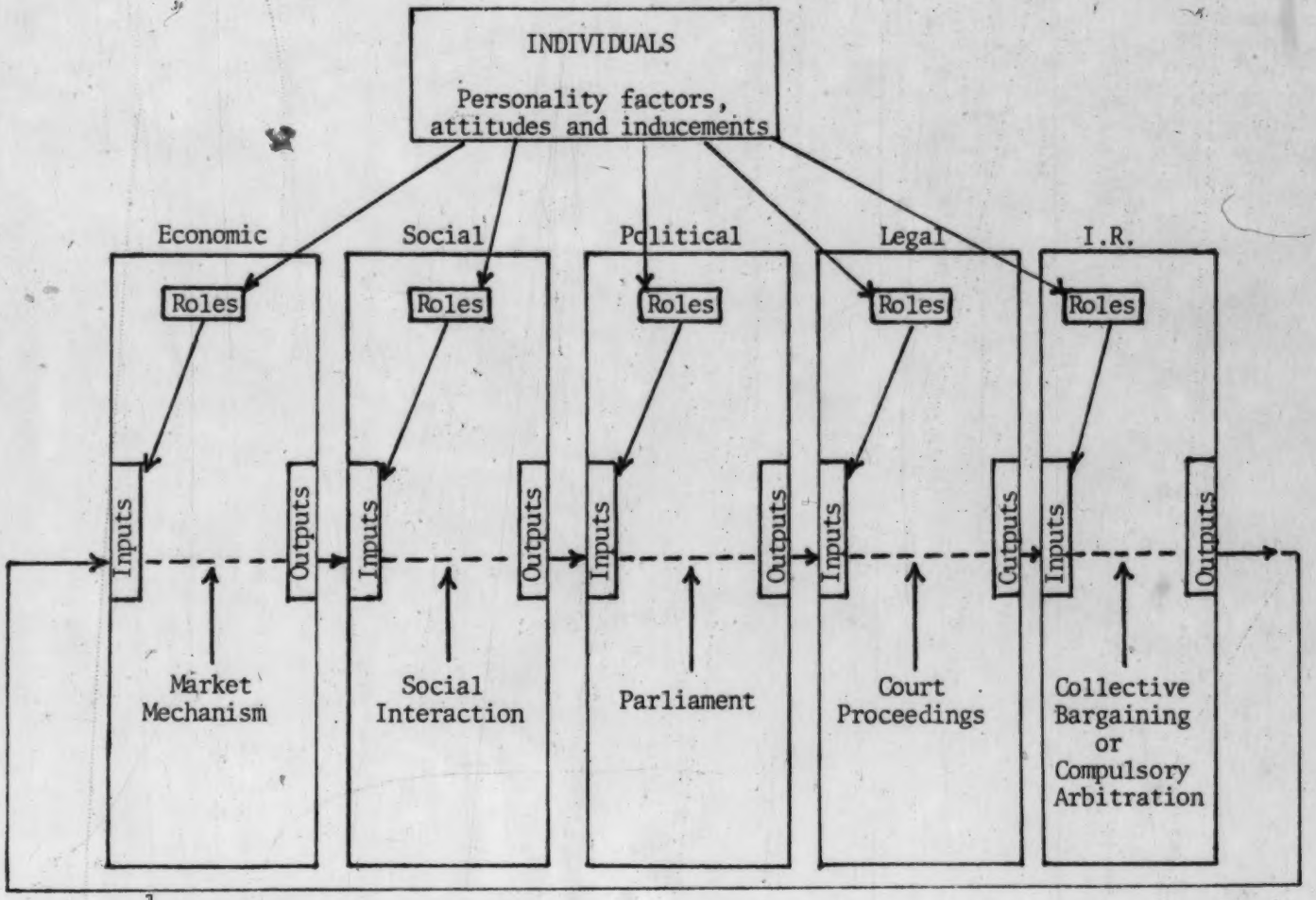


INDUSTRIAL RELATIONS SYSTEMS THEORY

The industrial relations open systems theory presented by Hameed indentifies five systems i.e. economic, social, political, legal and industrial relations which are treated as interdependent with conceptual similarities in their structure and processes. See Diagram 3. The relationships between systems are not only interdependent but causal and integrated.

Inputs are defined firstly as an individual's participation in any of the systems and secondly as outputs from other systems which become inputs into a given system. Outputs are defined as either positive or negative tangible, e.g. wages, or intangible, e.g. attitudes and perceptions, products. The internal environment includes ecology, ideology and values typical to a given system. The conversion mechanism transforms inputs into outputs and may consist of formal or informal processes.

Diagram 3 REPRESENTATION OF HAMEED'S OPEN SYSTEMS MODEL OF INDUSTRIAL RELATIONS[1]



[1] Hameed, Op. cit., Page 12.

The integration and causality of components is illustrated in terms of the following equations:

$$I_1 = f(p) \qquad (1)$$

$$C = f(I_1, I_2, I_3, E) \qquad (2)$$

$$E = f(I_1, I_2, I_3,) \qquad (3)$$

$$0 = f(I_1, I_2, I_3, E, C) \qquad (4)$$

[Where I_1 = participation of individuals (inputs), I_2 = physical or non-physical inputs from other systems within the society or the internal environment, I_3 = physical or non-physical inputs from outside the society, P = personality factors of participants, C = conversion mechanisms, E = internal environment, and 0 = output. Participation in any system is considered the only autonomous variable and depends on the inducements for the individual to participate.]

Equations (2), (3), and (4) are all a function of physical and non-physical inputs from within and without the society. The type and character of these inputs may vary however, hence the type and character of I_1, I_2, and I_3 may differ among the equations.

In terms of Hameed's equations, equation (4) will provide the framework for analysis. Chapter III will examine I_1, I_2, I_3: the personality and environmental inputs into industrial relations systems. Chapter IV will examine C, the conversion mechanism in each province. Chapter V will examine and compare 0, the outputs of each industrial relations system.

Individuals participating in health care collective bargaining, I_1, are hospital trustees, hospital administrators, professional negotiators, hospital employees, and government officials. The internal environment, E, may be characterized by the shared understanding amongst the participants. In the health care industry the internal environment is affected by the fact that the third party payer is not the employer and by the fact that many consider health care to be an "essential" industry which should not be disrupted under any circumstances.[1]

Inputs from other systems within the society, I_2, directly affect the health care industry e.g. labour legislation. Inputs from outside the society, I_3, which affect health care industry might be innovations in the terms of agreements which either union or management include in their demands. Characteristics of the health care industry are considered in greater detail in Chapter III.

Equation (1), is essentially a theory of participation. It illustrates that individuals participate in formal and informal groups

[1] The author conducted a survey of administrators Alberta health care institutions in April 1976 in which 74% of the respondents felt that hospital workers should not be allowed to strike, 59% felt that hospital workers should not be locked out, and further 84% felt that the government should, if necessary, legislate workers back to work. See Appendix 2 for details. Workers in these institutions were not surveyed.

because of personality factors i.e. what they are and what inducements they receive. "The level of individual participation depends upon the urgency and hierarchy of needs. Thus, need satisfaction is the stimulus for participation in any system".[1] Equations (3) and (4) purport to explain change in ideology, environment, and output respectively.

Equal (2), the conversion mechanism, is particularly significant for comparing provincial employers' organizations in the health care industry for it purports to explain how and why labour, management and government interact. "Equation (2) explains that whenever individual participation (I_1), inputs from other systems (I_2), inputs from outside the society (I_3), and internal environment (E) of industrial relations system change, the collective bargaining process will change."[2]

[1] Ibid., Page 18.

[2] Ibid., Page 21.

CHAPTER III

INPUTS IN THE HEALTH CARE INDUSTRY

Using the graphic illustration of Hameed's model, Diagram 3, in Chapter II, this chapter will describe the health care industry in Alberta, British Columbia, and Ontario. That is, inputs from the social, economic, political, and legal systems will be discussed. In terms of Hameed's equations, this chapter examines participation in the industrial relations system by actor in the health care industry I_1, inputs from other systems within the society I_2, and inputs from other societies I_3.

ACTORS INPUTS: (I_1)

Individuals participate in the industrial relations system through their membership and participation in formal and informal groups and organizations. According to Hameed's model, such participation in any system is a result of personality factors and inducements individuals receive. The groups and organizations within the industrial relations system discussed in this report are the employers' organizations and employee organizations, specifically nurses, general service workers, and technologists unions and professional associations in the three provinces. In addition, the various provincial governments are considered "individuals" in their roles as third party payer and legislator.

Input One, where $I_1 = f(P)$ may be expanded to illustrate the "individual" participating in health care industrial relations in the three provinces.[1]

I_1 = participation of : employer organizations,
employee organizations,
and government.

[1] "Groups" and "Organizations" are considered to be "Individuals" for purposes of this report.

Alberta

In Alberta, I_1, may be represented as:

Employer organization

Alberta Hospital Association, A.H.A.;

Employee organizations

Alberta Association of Registered Nurses, A.A.R.N.;
Alberta Certified Nursing Aids Association, A.C.N.A.A.;
Alberta Registered Dieticians Association, A.R.D.A.;
Alberta Society of Occupational Therapists, A.S.O.T.;
Alberta Union of Public Employees, A.U.P.E.
Association of Chartered Physiotherapists of Alta, A.C.P.A.;
Canadian Union of Public Employees, C.U.P.E.;
Health Sciences Association of Alberta, H.S.A.A.;
International Union of Operating Engineers, I.U.D.E.;
Service Employees International Union S.E.I.U.;
Speech and Hearing Association of Alberta, S.H.A.A.;

Government

Alberta Hospital Services Commission, A.H.S.C.;

where the A.H.A. is the employers' organization and the A.H.S.C. is the relevant government agency allocating funds to health care institutions. In 1975, all the unions and employee groups mentioned above bargained collectively with the A.H.A.

In a brief submitted to the Board of Industrial Relations August 21, 1972, the A.H.A. recommended that ultimately, there should be only four bargaining units in the health care industry. These units would be nursing, paramedical, general service, and nursing auxiliary. The rationale of the A.H.A. in recommending these four units was a follows:

"The occupations falling into the nursing groups were fairly easy to determine inasmuch as the nursing group is the most easily identifiable of any employee group working in a hospital. The people in this group have very definite community of interest and basically the same type of responsibility."[1]

"The second group, commonly referred to as the paramedical group, were also looked at in view of their training and their responsibilities to the hospital and patients alike. They form what can be considered a professional and technical group in that some occupations require a university education while others require training from within a technical institute. Many of these classifications are governed by a code of ethics, perhaps the most common factor reflected by this group."

"The third group of employees, the general service workers, are also similar in nature as has been demonstrated over a good number of years by their association together in trade unions."

"The fourth and final group is composed of those people providing non-professional nursing care. This comprises predominantly of certified nursing aids and certified nursing orderlies. In viewing the similarities between these two classifications, it is quite possible to say that there is really only one classification with two factors - male and female. We see this group as being large enough to constitute a viable organization for the purpose of collective bargaining."

[1] Alberta Hospital Association, Brief to the Board of Industrial Relations, 1972.

The Health Sciences Association of Alberta (H.S.A.A.) submitted a brief to the B.I.R. in 1972 recommending one unit, namely the H.S.A.A., to meet the growing challenge of labour relations and collective bargaining for professional groups in Alberta. In their brief, the H.S.A.A. did not identify those other professional associations that should join H.S.A.A. Three professional associations however responded to the H.S.A.A. brief, i.e. the Alberta Registered Dieticians Association (A.R.D.A.), Association of Chartered Physiotherapists of Alberta (A.C.P.A.), and the Speech and Hearing Association of Alberta (S.H.A.A.), expressing their objections to the possibility of H.S.A.A. acting as their bargaining agent. Essentially the objections which concerned these professional groups centred on the differentiation between "professionalism" and "unionism", their aversion to the strike possibility, and their concern to be able to control professionals within their respective associations including making regulations concerning continuous upgrading of skills.[1]

The Canadian Union of Public Employees agreed in principle with the A.H.A. that three or four bargaining units were optimal but they did not specify what occupational groups should be represented by a single bargaining unit.[2] The S.E.I.U. identified, but did not

[1] Taken from A.R.D.A., A.S.O.T., A.C.P.A., and S.H.A.A., briefs to the Board of Industrial Relations, August 21, 1972.

[2] Submission to B.I.R. by C.U.P.E. in 1972.

define six possible occupational groups i.e. service support staff, operating engineers, nurses, office staff, diagnostic staff, and professionals. The S.E.I.U. explicitly stated that they did not want their bargaining unit eroded.[1]

[1] Submission to B.I.R. by the S.E.I.U. in 1972.

British Columbia

In British Columbia, I_1, may be represented as:

Employer organizations

British Columbia Hospitals Association, B.C.H.A.;
Health Labour Relations Association, H.L.R.A.;

Employee organizations

Health Sciences Association of B.C., H.S.A.B.C.;
Hospital Employees Union, H.E.U.
International Union of Operating Engineers, I.U.O.E.;
Registered Nurses Association of B.C., R.N.A.B.C.;

Government

British Columbia Hospital Insurance Service, B.C.H.I.S.

where the H.L.R.A. is the employers' organization and the B.C.H.I.S. is the relevant government funding agency. The B.C.H.A. represents its member institutions on all issues other than industrial relations. Membership in the H.L.R.A. is contingent on membership in B.C.H.A.[1]

[1] Health Labour Relations Association, Constitution.

Three major unions and professional associations represent hospital workers in British Columbia i.e. the Hospital Employees Union (H.E.U.), the Registered Nurses Association of British Columbia (R.N.A.B.C.), and the Health Sciences Association of British Columbia (H.S.A.B.C.). The International Union of Operating Engineers (I.U.O.E.) is present in some institutions. Although British Columbia has relatively few bargaining units, the H.E.U. in a brief to the provincial government stated that "hospitals in B.C. are now faced with a proliferation of collective bargaining units and agreements ... we believe that there should be one broad inclusive bargaining unit ... hospital workers, whether they are called "professionals" or "lay" staff have a community of interest in that they are all involved in providing services to patients. The "team approach" to health care delivery in the hospital sector cannot have real meaning while the proliferation of bargaining units exist."[1] In addition to recommending one union to bargain for all hospital workers, the H.E.U. also recommends that the provincial government, through the British Columbia Hospital Insurance Service, negotiate collective agreements rather than the employers' organization.[2]

[1] Hospital Employers Union, Local 180, Brief: Recommendation for Change in Health Care Delivery and Hospital Operation, February 1973, Pages 57 and 58.

[2] Ibid., Pages 50 - 53.

Ontario

In Ontario, I_1, may be represented as:

Employers organizations

Hospital Personnel Relations Bureau, H.P.R.B.;
Ontario Hospital Association, O.H.A.;

Employees organizations

Canadian Union of Operating Engineers, C.U.O.E.;
Canadian Union of Public Employees, C.U.P.E.
Civil Service Association of Ontario, C.A.S.O.;
International Union of Operating Engineers, I.U.O.E.;
Ontario Nurses Association, O.N.A.;

Government

Ontario Health Insurance Plan, O.H.I.P.;

where the H.P.R.B. is the employers' organization providing collective bargaining services, O.H.A. provides a labour relations information bulletin to all Ontario hospitals and represents its member institutions on all other matters, and O.H.I.P. is the relevant government funding agency. There are a number of professional associations not listed above which also make representation to O.H.A. and H.P.R.B., e.g. Canadian Society of Hospital Pharmacists Ontario Branch.

C.U.P.E. and S.E.I.U. are the major unions representing service workers. In 1974, C.U.P.E. and S.E.I.U. accounted for about 30,000 hospital workers under 150 collective agreements.[1] The Ontario Nurses Association (O.N.A.) represented 16,000 registered and graduate nurses in 1974, or approximately 60% of the 27,500 general nurses employed in Ontario public hospitals. The I.U.O.E., the Canadian Union of Operating Engineers (C.U.O.E.), and the Civil Service Association of Ontario (C.S.A.O.) also represent hospital workers. Physiotherapists, dietitians, pharmacists, and medical record librarians are represented by their respective professional associations.[2] For the purpose of certification for collective bargaining, the Ontario Labour Relations Board has recognized five groups of employees appropriate for certification i.e. service, office, operating engineers, professional nurses, and paramedical.[3] The O.L.R.B. had not, as of 1974, established policy permitting each paramedical professional association to "carve out" their members as a separate unit for collective bargaining.[4]

[1] Alden, R.E. et.al., Op. cit., Page 12.

[2] These associations are not listed in I, as the author was unable to find references which described them in any detail.

[3] Alden, R.E. et.al., Op. cit., Page 36.

[4] Ibid., Page 36.

While British Columbia has had few bargaining units, Ontario characterizes the other end of the continuum with several bargaining units and a multiplicity of collective agreements for each unit. During 1974, there were indications of a trend toward multi-hospital bargaining.[1] The S.E.I.U., C.U.P.E., and O.N.A. have all achieved settlements covering various groups of hospitals.

These three unions indicated their views on province-wide bargaining in written submissions to the Inquiry Commission.[2] The O.N.A. and C.U.P.E. "placed considerable emphasis on the goal of province-wide bargaining in public hospitals in Ontario."[3] Their arguments were that hospital employees performing a certain job should be paid the same regardless of the hospital or geographic area, and secondly that uniform wages and working conditions resulting from province-wide bargaining would "force employers and and arbitrators to use criteria other than settlements in compafable hospitals as a basis for their awards" i.e. nature of the task.[4]

[1] Ibid., Page 36.

[2] Ibid., Page 37.

[3] Ibid., Page 37.

[4] Ibid., Page 37.

The S.E.I.U. also favours province-wide bargaining in principle but considers that compulsory or legislative means to affect such hospital bargaining "could create a level of disorder that might far outweigh possible benefits of such a system."[1] Supoorting province-wide bargaining is the fact that employees of Ontario Government psychiatric hospitals have province-wide bargaining and master contracts applicable across the province.

In a letter to the author, John Sheriff, Executive Director of the H.P.R.B. summarized the current structure of unions in Ontario.[2] He stated,

[1] Ibid., Page 37.

[2] See Appendix 3.

"The structure now in effect for group bargaining in the industry is a central system which, on the management side, reflects the type of organizational plan which is shown on page 38 of the Report. There is not an "accredited employers' bargaining agency" however, nor have there been any moves towards a joint council of trade unions. Thus the hospitals which have bargaining units with a particular union find themselves grouped together for negotiations with that union, but without any formalized relationship (other than the close liaison which one might expect) to the negotiations that take place with other unions.

As you can imagine, the engineering unions did not take kindly to the recommendation that their craft units should be eliminated from the structure of the bargaining, and therefore they are still very much in existence, and currently the Canadian Union of Operating Engineers is jointly negotiating with a group of hospitals.

This type of half-way house in bargaining structures is, so far as the nurses are concerned (the Ontario Nurses' Association is the union concern) conducted on a province-wide basis. To all intents and purposes the service workers negotiations with CUPE and SEIU are also on a province-wide basis, though there is no movement towards a "master contract" as yet. This is an objective which the ONA would like to achieve, and there is more credibility about that for them than there is for the service workers. It is thought by some that collective agreements for the latter should, in monetary terms, reflect the wage rates which are paid in the different regions. The acceptance of provincial wage rates would be a difficult pill for hospitals to swallow in so far as they would then, in the remoter areas become the trend setters. Reaction from local industries and other employers would obviously be adverse to this."

[1] Referring to Page 38 of the Report of Hospital Inquiry Commission 1974 by Alden, et. al. ...

ENVIRONMENTAL INPUTS: (I_2)

Hameed's model indicates that any given society is a composite of economic, social, political, legal and industrial relations systems. This section will analyze the first four systems to identify their influences on the health care industrial relations systems in the selected provinces.

Economic System

Health care in all provinces is provided on a subsidized basis to all residents. Costs of these universal health care plans have been shared by both provincial and federal governments. In 1975 however, the federal government served notice to all provinces that the current formula for health care cost sharing would expire in 1980. Currently, the federal government pays the larger portion of the costs in the "have not" provinces such as the Maritimes. In Alberta, British Columbia, and Ontario the formula for cost sharing results in variations from year to year but in general the provinces pay fifty percent of health care costs. By 1980 all provincial governments will be required to rengotiate their cost sharing agreements with the intent that federal input will either decrease or shift from the subsidization of diagnostic and treatment facilities to the support of non-institution based health programs.[1]

The implication for the provincial governments is that they will be expected to bear more of their health care costs. As indicated in Chapter I, labour accounts for 70.1% of the total health

[1] Published data on the future of federal cost sharing in health care is unavailable. The basis for this section was an interview with Chalmers Whitelaw, Financial Consultant, Alberta Hospital Association.

care bill. Thus, with the increase in the health care industry over the past two or three years, there is a great incentive for employers to increase operating efficiency. In addition, many diagnostic and treatment facilities have closed beds which resulted in personnel being laid off. Under the present Anti-Inflation Board guidelines, wage rates can increase by certain allowable percentages over three years. Even without these guidelines, it might have happened that unions would have lessened their demands in order to prevent their members from losing jobs due to closure of beds. In any case, health care is becoming more expensive and governments are trying to prevent passing these costs to the taxpayer. The implication for unions is that wages cannot be expected to increase without some balancing measure, such as lay-offs, to keep health care costs at a level which the government and public can support.

Social System

For purposes of this thesis, the social system characterizing health care labour relations is limited to the groups and organizations identified in the previous section and those individuals and institutions which comprise them. The significant social factors however which influence the relationships among these individuals, groups, and organizations is the essential nature of the health care industry and the adversary relationship present in union-management negotiations.

The essential nature of the health care industry may be demonstrated in that Ontario health care workers are not allowed to strike.[1] (Details of legislation affecting the health care industry is presented in a following section.) It was also illustrated in the results of an Alberta survey of health care institutions in which 74% of the respondents felt that hospital workers should not be allowed to strike. In addition, several of the respondents indicated in written

[1] Revised Statutues of Ontario, The Hospital Labour Arbitration Act, Chapter 208, October 1974, Section 8 (1), Page 9.

comments their feelings of the essential nature of the health care industry.[1] A major Edmonton hospital management representative commented that;

> "It is my personal view that hospital workers should not have the right to strike. In Alberta, the majority of hospital workers do have the right to strike since they are under the aegis of the Alberta Labour Act. Since the Federal Government gave its employees the right to strike, more pressure have been put on other governmental and quasi-governmental organizations to grant their employees the right to strike. However, some members of society such as the ill need protection and therefore the assurance that when they are placed in institutions they will not have any of the services to them disrupted through strike."

[1] Response by an Edmonton hospital administrator, Voigt, B.C. from "A Survey of Perceived Employer-Employee Conflict in the Alberta Health Care Industry," April 1976. See Appendix 2.

The adversary nature of the union-management relationship has been identified as a characteristic which, especially in a public service, should be eliminated. The expression, "There must be another way" captures the feeling that conflict in collective bargaining is not the best solution and that an alternative should be found. A management representative of a major Calgary institution commented in the same survey.[1]

> "My answer (to the question 'Do you feel hospital workers should have the right to strike?') ... is a qualified yes not only in the context of today's totally adversary system. It is conceivable that unions could take irresponsible action to the level which would make it necessary for the employer to bring about a decisive result and lock out could be necessary.
>
> I believe that the right to strike is meaningless when the employer is essentially society as a whole. Strike is a technically accepted industrial relations tool only when both parties to the dispute stand to loose equally in an economic sense. I would not suggest that the right to strike should be removed so much as it should be replaced with something more effective. Certainly, everyone has a right to be heard and to have a fair determination made regarding his demands. Strike within the public service can never serve those ends."

The existing labour relations system channels conflict between managers and the managed through collective bargaining. To suggest however that there is some potentially useful level

[1] Ibid..

of conflict in a system requires some notion of regulation or control. There is in fact legislative control as an ultimate sanction and the social control in the form of expectations and roles. The objective of conflict management, as Zupanov offers, is not to search for ultimate solutions to conflict per se but to keep conflict creative and useful.[1] Zupanov goes on to state that "The exercise of power is ... required in order to avoid a stalemate at the bargaining table and to prevent the government from intervening ..."[2] The advantages of a system with the strike and lockout as sanctions may be in the catharsis effect they provide.

[1] Josip Zupanov, "Two Patterns of Conflict Management in Industry", Industrial Relations, Vol. 12, No. 2, May 1973.

[2] "Ibid.", Page 214.

The adversary nature of the relationship in collective bargaining may be considered as a creative social force rather than something which should be eliminated.

Organizations supporting collective bargaining should therefore be structured to make the best use of conflict. Alternative organizational structures were identified by the A.H.A. as possible for the health care industry i.e. individual hospital bargaining, regional bargaining, and provincial bargaining.[1] Appendix 4 presents details of the alternatives.

[1] Alberta Hospital Association, Report on Provincial Labour Relations, 1975, Appendix B1.

Political System

The political system in each province, although characterized by different political parties, is similar i.e. characterized by the western democratic tradition. The period of the early 1970's was marked by changes in long standing provincial governments in Alberta and British Columbia. Although no attempt has been made here to analyze the affect of different political philosophies on legislation, further research might indicate the implication on labour legislation by political philosophy. Currently, the Alberta government is Progressive Conservative, British Columbia has recently elected Social Credit to depose the New Democratic Party, and Ontario has a Progressive Conservative government. All three governments are faced with increased health care costs after 1980 when the current federal cost sharing agreement expires. While it may be premature to speculate on the options open to politicians vis a vis providing health services in the face of rising costs, it appears that governments are not afraid of cutting budgets and inducing employers to close beds and lay off personnel.

Legal System

The aspect of the legal system considered in this chapter is legislation pertaining to the health care system and industrial relations. Three major areas of difference can be identified as distinguishing each province's legislation, the right to strike, the right for an employers' organization to be certified, and the existence of special legislation governing collective bargaining in the health care industry.

Most employees in Alberta hospitals are governed by the Alberta Labour Act which allows the strike.[1] Employees of the Foothills Provincial General Hospital, the Glenrose Provincial General Hospital, the University of Alberta, and the W.W. Cross Provincial Cancer Hospital are governed by the Crown Agencies Employee Relations Act and the Public Service Act and do not have the right to strike.[2] The Labour Code of British Columbia guarantees the right to strike for all employees.[3] The Ontario Hospital Labour Disputes Arbitration Act removes the strike potential from all hospital employees.[4]

[1] Revised Statutes of Alberta, 1970, The Alberta Labour Act, Section 66 (1) page 29; Sections 125, 126, page 56.

[2] Revised Statutes of Alberta 1970, The Crown Agencies Employees Relations Act, Chapter 79, November 1974, Section 9, page 4.

Revised Statutes of Alberta 1970, The Public Service Act, Chapter 298, June 1974, Section 37, page 15.

[3] Revised Statutes of British Columbia, 1960, Labour Code of British Columbia, 1973, Section 2 (1) page 2099, Section 73 (1) page 2110-12.

[4] Revised Statutes of Ontario, The Hospital Labour, Disputes Arbitration Act, Chapter 208, October 1974 Section 8 (1) page 9.

The right for the hospital employers' organization to be accredited is not allowed in Ontario according to the Labour Relations Act.[1] The Labour Code of British Columbia however does not allow for accrediation of the hospital employers' organization.[2] Part 4, Division 3 of the Alberta Labour Act specifies certain duties of registered employers' organizations.

Labour legislation specific to the health care industry has been instituted in Ontario. The Hospital Labour Disputes Arbitration Act of Ontario establishes an arbitration procedure to replace the strike when conciliation has been ineffective.[3]

[1] Revised Statutes of Ontario, The Labour Relations Act, Chapter 232, March 1975, Section 106, Page 54.

[2] Op. cit., Section 59, page 2110-8.

[3] Op. cit., Section 4, page 4.

These differences may be summarized by the following table:

Table 6 LEGISLATIVE DIFFERENCE AMONG ALBERTA, BRITISH COLUMBIA, AND ONTARIO

	Alberta	British Columbia	Ontario
Right to strike	yes/no	yes	no
Right for employers' organization to be accredited.	unclear	yes	no
Special health labour legislation	no	no	yes

INPUTS FROM OTHER SOCIETIES: (I_3)

Inputs from other societies could take the form of influences affecting the health care industry in terms of technology or organization, or influences affecting the terms in collective agreements e.g. clauses affecting the length of the work week negotiated in agreements in the United States could be expected to emerge in Canadian workers' demands. Such inputs are not dealt with explicitly in this report other than to recognize that they exist.

Summary

In summary, it may be concluded that the health care industry in each province is characterized by similarities as well as differences. The legal system provides some differences in legislation. The social system is characterized in each province by the essential nature of the health care industry and by the adversary nature of the union-management relationship but is differentiated in the structure of the unions. British Columbia has virtually provincial unions, Alberta has some essentially provincial unions e.g. C.U.P.E. and the A.A.R.N. and some local unions e.g. A.U.P.E. and Ontario's unions are quite fragmented. It may be concluded that the political, economic, and legal systems in each province do not appear alone to significantly affect the structure of the employers' organization. Rather, one aspect of the social system, namely union structures does not appear to affect the structure of the employers' organization.

In terms of Equation (4),

$0 = f(I_1, I_2, I_3, E, C)$, outputs from the industrial relations systems in the health care industry are a function of actors inputs, environmental inputs and inputs from other societies. That is, Equation (4) becomes

$0 = f$ (I_1 actors inputs: employer's organizations, employee's organizations, and government;

I_2 = environmental inputs: social, economics, political, and legal;

I_3 = inputs from the other societies: technology, and terms of agreement;

E = the internal environment, and

C = the conversion mechanism).

Chapter IV will describe the conversion mechanism, which has developed in each province to deal with health care collective bargaining. Emphasis will be placed on the employers' organization and their charactertistics.

CHAPTER IV

COMPARISON OF THE CONVERSION MECHANISMS IN THE HEALTH CARE INDUSTRY IN ALBERTA, BRITISH COLUMBIA, AND ONTARIO

This chapter presents a description and comparison of the conversion mechanisms operating in the health care industry in Alberta, British Columbia, and Ontario. In terms of Hameed's equations, the conversion mechanism, C, is a function of I_1, I_2, I_3, and E, where E now represents the shared understanding amongst participants in the internal environment. As Chapter III indicated, a part of the shared understanding amongst participants includes the adversary nature of collective bargaining. This chapter will describe a contributing factor to shared understanding, E, i.e. the historical development of health care collective bargaining in each province.

Emphasis will be placed on the development of the employer's organization.

[1] Hospital bargaining structures in Ontario and British Columbia are discussed in the Report of the Hospital Inquiry Commission, November 1974, op. cit., Pages 37-40.

A HISTORICAL REVIEW - THE DEVELOPMENT OF SHARED UNDERSTANDING AMONG PARTICIPANTS: (E)

Alberta

Bargaining in Alberta hospitals has evolved from local bargaining to essentially provincial bargaining in 1976.[1] Those hospitals which do not explicitly cooperate in provincial bargaining adopt the negotiated agreement either in whole or in part and are, therefore, effectively a part of province-wide negotiations. Both employers and unions recognized the advantages in provincial bargaining which contributed to its relatively quick development.

The individual Alberta hospital, through its Board of Directors, is legally responsible for negotiating, interpreting, and administering the collective agreement.[2] In practice, however, hospitals delegate authority for negotiating agreements to the Alberta Hospital Association (.A.H.A.) and retain the right to ratify the agreement. It appears to be possible, however, without any changes in legislation, for hospital boards to delegate bargaining authority to the A.H.A. and for the agreement to be binding on the hospital without further approval by the

[1] Appendix 5 provides details of the development in Alberta health care collective bargaining taken from the A.H.A. Report 1975.

[2] Revised Statutes of Alberta, The Alberta Hospital Act, Chapter 174, November 1974, Section 33, Page 18.

hospital board.[1] If Association negotiated agreements were automatically binding on hospitals, delays inherent in the ratification process would be eliminated, however the issue of hospital autonomy is still sensitive. Hospitals may, if they wish, bargain independently.

In Alberta, the major groups - the Alberta Association of Registered Nurses (A.A.R.N.), Canadian Union of Public Employees (C.U.P.E.), and the Alberta Union of Public Employees (A.U.P.E.) - have constituted the bulk of the bargaining effort by the A.H.A. However several paramedical and professional groups are increasing the workload of A.H.A. negotiations e.g. Health Sciences Association (H.S.A.). It is recommended to the Board of Industrial Relations in 1972 by the A.H.A. that professional associations combine for bargaining.[2] It appears at this date that the idea is favourable to the employee associations involved.[3] The days of continued independent bargaining for professional associations are numbered since the B.I.R. has made the decision that only four or five units will be recognized by the Board.[4]

[1] Interview with Dave Ruptash, Director Consultative Service, Alberta Hospital Association, May 17, 1976. Mr. Ruptash considers section 29 of the Alberta Hospital Act to permit hospitals to delegate authority for ratification of contracts.

[2] Alberta Hospital Association, Brief to the Board of Industrial Relations, 1972.

[3] This is the opinion of Leo Lancaster, Chief Negotiator, Alberta Hospital Association, stated in an interview with the author on January 29, 1976.

[4] Interview with Ron Bronston, Board of Industrial Relations, April 1976.

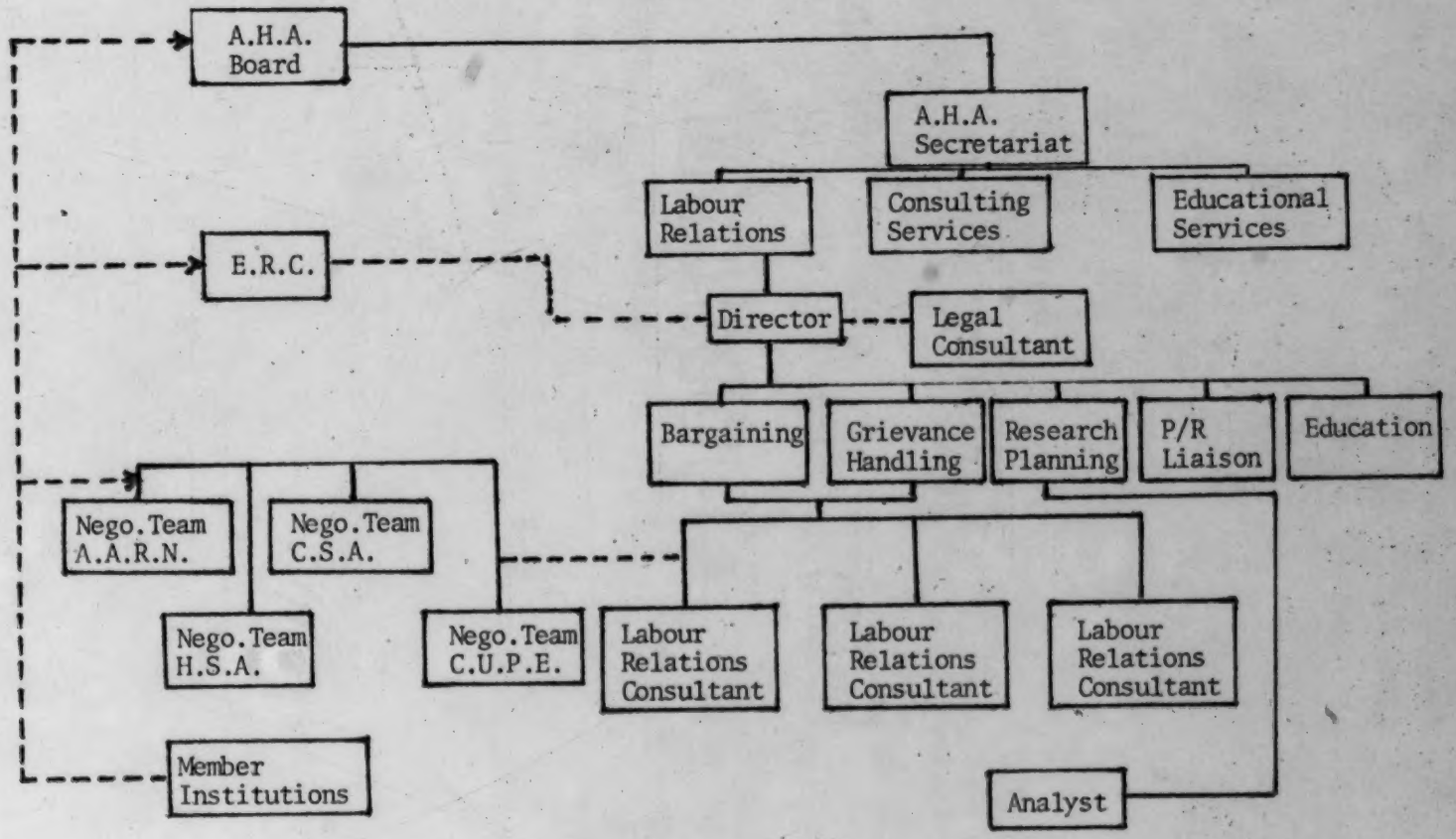
Actual interpretation and administration of the collective agreement is the responsibility of each hospital. Since problems of contract interpretation do arise, consultation is available through the A.H.A. for clarification. Interpretation, as a result, may vary among hospitals.

Prior to 1970, the employers' organization, the Alberta Hospital Association, performed minimal industrial relations services for some member institutions on an ad hoc basis. In the Spring of 1970, the Employment Relations Committee (E.R.C.) was formed to provide industrial relations policies and guidelines for the A.H.A. The E.R.C. was made up of trustees, regional representatives, and appointees of the Board of Directors of the A.H.A. Appendix 5 details the development of the E.R.C. including its members, resource subcommittee, lines of communication, and negotiating teams.

Changes were made to the E.R.C. in the Fall of 1974, when criticism of the expertise of trustees in labour relations resulted in the inclusion of members of senior management from various types of institutions.[1] In additional, research was now provided by each negotiating team for its own purposes rather than by a resource committee. In the Fall of 1975 further organizational changes were made which included primarily the delineation of support programmes

[1] A.H.A., Report on Provincial Labour Relations, 1975.

Diagram 4 ORGANIZATIONAL STRUCTURE OF A.H.A. LABOUR RELATIONS FROM SEPTEMBER 1975[1]



[1] A.H.A., Report 1975.

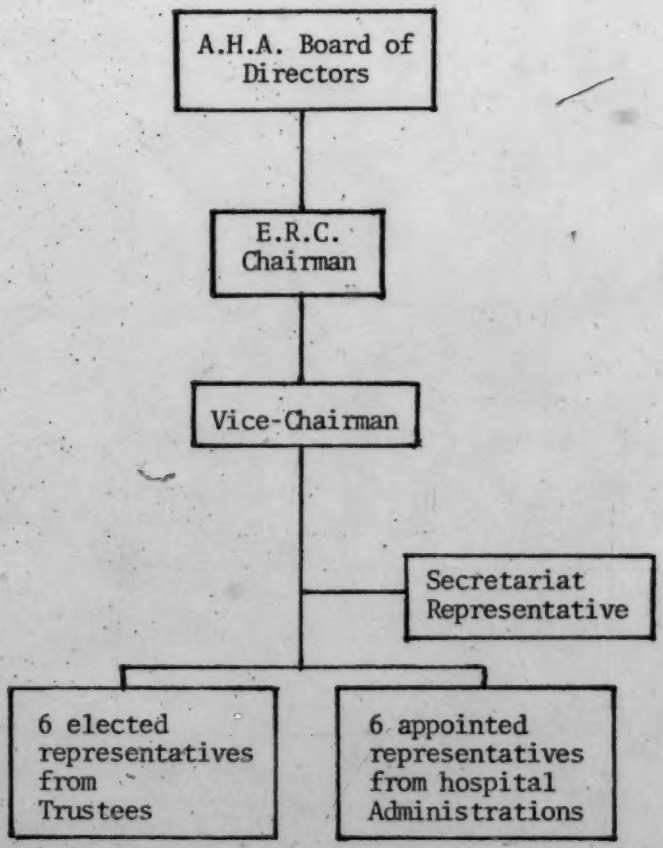
and services and clarification of negotiating team responsibilities.[1] Diagram 4 illustrates the current organizational structure of the A.H.A. industrial relations function.[2] The E.R.C. underwent further structural changes when in 1975 the A.H.A. changed the basis of E.R.C. membership from a regional basis to representation by type and size of institution. The current 1976 E.R.C., illustrated in Diagram 5, is composed of six trustees and six hospital administrators and still maintains representation by type of institution.[3]

[1] Ibid..

[2] Ibid..

[3] Interview with Leo Lancaster, Negotiator, Alberta Hospital Association, April 1976.

Diagram 5 - E.R.C. STRUCTURE OF THE A.H.A. AS OF JANUARY 1976[1]



[1] Interviews with Leo Lancaster, Negoiator, A.H.A., April 1976.

In brief, the make up of the E.R.C. has evolved from total trustee representation on a geographic basis to a mixture of trustees and senior management staff by type and size of institution. What does not appear on the original charts however is the change from relatively unsophisticated E.R.C. representatives in industrial relations to representatives who have considerable experience in health care industrial relations.[1] This reflects the growing emphasis on the importance of hospital industrial relations by the A.H.A. and the necessity for expertise.[2] What should also be emphasized is the continued reliance on volunteers from member institutions who compose both the E.R.C. and all negotiating teams.

[1] Interview with Dave Ruptash, Director Consultative Service, Alberta Hospital Association, July 1975.

[2] Ibid..

British Columbia

Bargaining in British Columbia hospitals is also conducted on essentially a province-wide basis. The structure has evolved from local hospital bargaining to regional bargaining and now to province-wide bargaining.[1] Province-wide bargaining in British Columbia appears to have been facilitated by the relatively small number of unions on the scene, i.e. the Hospital Employees Union (H.E.U.), the Registered Nurses Association of British Columbia (R.N.A.B.C.), and the Health Sciences Association (H.S.A.) which includes the paramedical groups of laboratory technologists, pharmacists, occupational therapists, physio-therapists, remedial gymnasts, medical social workers, and medical records librarians.[2]

For each union a master contract was negotiated for major items of pay and working conditions and these provisions applied across the province.[3] In the H.E.U. contract, and to some extent H.S.A. contract, a special northern allowance was applicable.

The individual British Columbia hospital is legally responsible for negotiating and administering the collective agreement.[4] However

[1] Alden, R.E., et.al., Op. Cit., Page 38.

[2] Ibid..

[3] Negotiating procedures were discussed with H.E.U. negotiators at a meeting in Vancouver, February 21, 1974.

[4] Revised Statutes of British Columbia, Hospital Act, Chapter 178, December 1973, Section 4, (1b), Page 1800.

in practice, until 1975, each hospital delegated bargaining authority to the British Columbia Hospital Association (B.C.H.A.).

Prior to May 1975, the British Columbia Hospital Association served its member institutions in industrial relations similar to Alberta. There was an Employee Relations Council, with geographic representation, which was responsible for the formulation of policies on all industrial relations matters.[1] The details of B.C.H.A. prior to May 1975 is presented in Appendix 6. The organizational structure of the B.C.H.A. and its E.R.C. prior to May 1975 is presented on the following page.

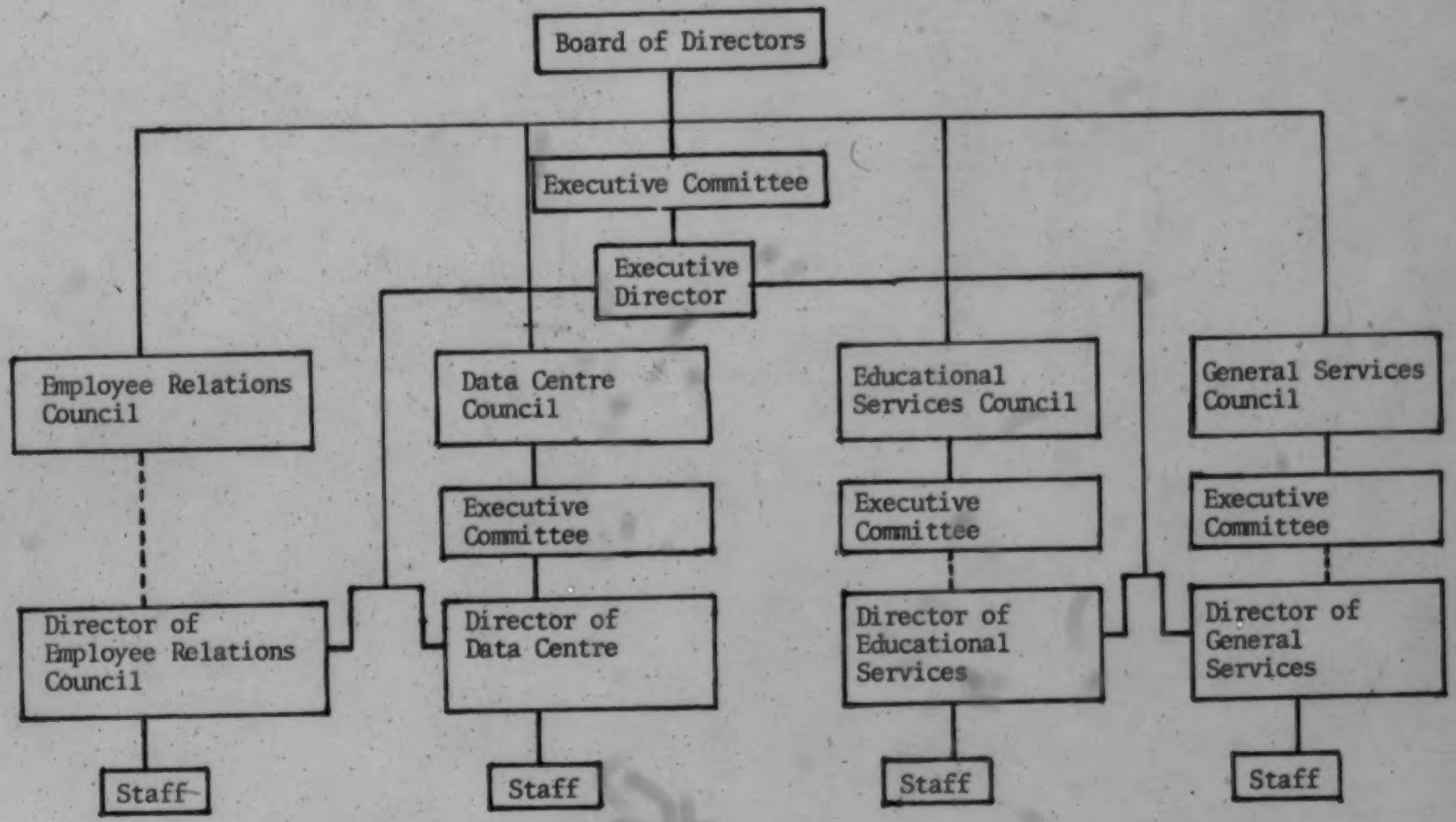
In 1974, two reports were published recommending changes in B.C.H.A.'s industrial relations function.[2] Both reports recommend an independent health industrial relations organization. Fullerton's rationale for the recommendation of a new organization was that the credibility of B.C.H.A. was under sttack by third party interests such as unions and government and thus jeopardizing other important areas of concern to B.C.H.A., such as public relations, representation

[1] B.C.H.A., "Organizational Structure and Terms of Reference," Revised 1971.

[2] Blair, D.R., Special Officer Report: Hospital Industry Collective Bargaining System, submitted to the Honourable Minister of Labour. Victoria, B.C., November 5, 1975.

Fullerton, E.D., "Final Report to the Special Committee to study the role and Organizational Structure of the Employee Relations Council," submitted to the British Columbia Association of Hospitals and Health Organizations, September 4, 1974.

Diagram 6 BRITISH COLUMBIA HOSPITALS' ASSOCIATION ORGANIZATIONAL CONCEPT OF COUNCILS[1]



Staff Directors of Council have a functional relationship to the Councils but a line relationship to the Executive Director of B.C.H.A.

[1] B.C.H.A., Organizational Structure and Terms of Reference, Revised 1971.

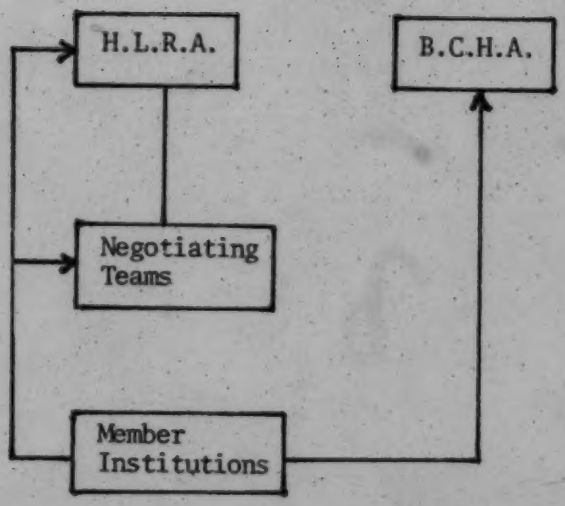
to government, liaison with other health agencies, and other service programs.[1] Blair indicated similar reasoning when he stated that the industrial relations organization in the health care industry should stand apart from other associations in the industry which make public presentations and representations to the government.[2] As a result of these recommendations and the general unrest in British Columbia health care industrial relations, the H.L.R.A. was established in May 1975.

Details of the H.L.R.A. taken from its Constitution are provided in Appendix 7 but, in brief, the objectives are essentially to provide industrial relations services to British Columbia health care institutions. Membership in the H.L.R.A. is conditional upon membership in the B.C.H.A. This relationship is illustrated in Diagram 7. Directors of the H.L.R.A. are appointed regionally by their district and must be trustees or executive staff of a member institution. Negotiation Committee consists of the President of H.L.R.A. or his designate, salaried positions, and other individuals from member institutions appointed by the Board of H.L.R.A. The organizational structure of H.L.R.A. is represented in Diagram 8.

[1] Fullerton, E.D., "Ibid.".

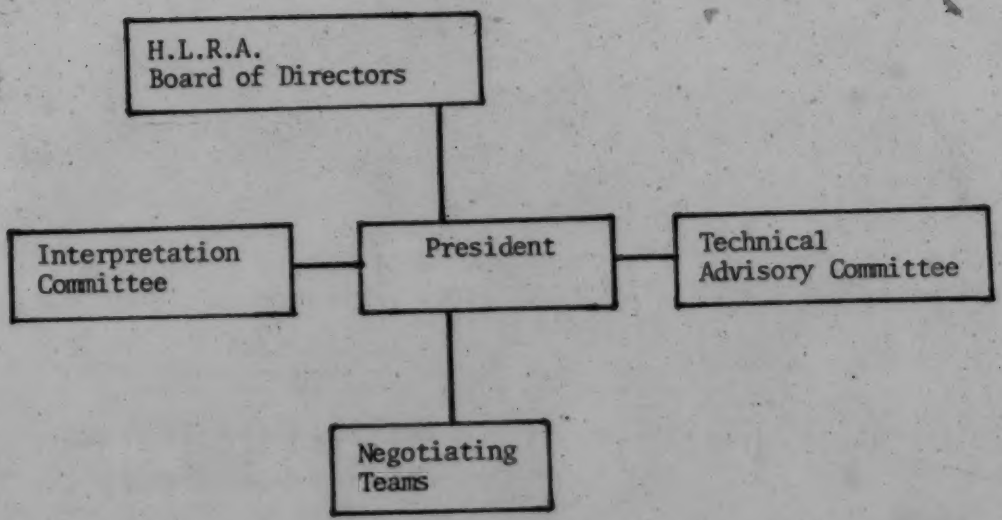
[2] Blair, D.R., Op. cit.

Diagram 7 RELATIONSHIP BETWEEN H.L.R.A. AND B.C.H.A.[1]



[1] Health Labour Relations Association, Constitition, British Columbia, 1975.

Diagram 8 ORGANIZATIONAL STRUCTURE OF H.L.R.A.[1]



[1] Health Labour Relations Association, Constitution, British Columbia, 1975.

Ontario

Bargaining in Ontario hospitals has been essentially on a local level with some small groups of hospitals cooperating in certain negotiations. Both employers and unions have in the past been reluctant to conduct province-wide negotiations.[1] The individual hospital is responsible for negotiating and administering the collective agreement.[2] The employers' representative in Ontario is not the Ontario Hospital Association but the Hospital Personnel Relations Bureau (H.P.R.B.). The Bureau is an independent organization established in 1968 to provide industrial relations data, consultation, and direct negotiation services to hospital managements.[3] The O.H.A. represents its members on budgeting and political issues. As in Alberta and British Columbia the Ministry of Health has no direct involvement in hospital collective bargaining.

The Ontario Hospital Association (O.H.A.) offers some services relevant to collective bargaining such as representations to the Ministry of Health on budget issues and distributes to its member institutions information on wages and fringe benefits. Specialized

[1] Alden, R.E., et.al., Op. cit.

[2] Revised Statutes of Ontario 1970, The Public Hospitals Act, Chapter 378, December 1974, Regulation 729, Section 2, Page 62.

[3] Alden, R.E., et.al., Op. cit., Page 13.

collective bargaining functions, such as negotiating collective agreements, rests with the Hospital Personnel Relations Bureau. As of November 1974, 180 public hospitals were members of the H.P.R.B.[1]

The O.H.A. expressed its views on province-wide bargaining in a submission to the Inquiry Commission in October 1974.[2] The O.H.A. considers province-wide bargaining with nurses and paramedical personnel desirable provided that regional or district factors are taken into account. Bargaining with organized service and clerical personnel however is favoured on a regional basis for the reason that service and clerical workers are less readily indentifiable as belonging to a province-wide labour market than are nursing and paramedical groups. The O.H.A. further stated that group bargaining with service and clerical workers should be brought about voluntarily not through compulsory legislation.

The O.H.A. offered an organization plan, endorsed by the H.P.R.B., which would establish an Employee Relations Policy Committee as a standing committee of the O.H.A. with members from the O.H.A. Board of Directors, H.P.R.B. Board of Directors, and O.H.A. nominees. The responsibilities of this committee would be "to advise O.H.A. on matters of employee relations and to recommend policy to guide hospital management in these matters" and "to appoint necessary hospital people to

[1] Ibid..

[2] Ibid., Page 37.

steering or negotiating committees that may be periodically established for groups or province-wide bargaining."[1] The O.H.A. further contemplated Ministry of Health input at the level of the joint employer steering committee but not at the bargaining table. The Inquiry Commission however felt that the Ministry of Health should be represented at the bargaining table as an observer.[2] John Sheriff of the H.P.R.B. stated in his letter to the author that, from the point of view of the hospitals, Ministerial representation would be "a disturbing influence."[3] Specifically, he stated;

"One final point apropos of the representation of government at the bargaining table. In Ontario, this is not the case and while the Ministry of Health, as paymaster, is kepts well informed of the bargaining process, neither the government nor hospitals wish to have a representative of the Ministry at the bargaining table, for this would tend to reduce the position of hospitals to that of mere ciphers, and the bargaining would then seem to be taking place directly between unions and the government. This would not reflect the system of management of hospitals by local boards of trustees which is the practice in Ontario. Indeed it would go a long way to upsetting that arrangement, and would be a very disturbing influence."

The Ontario Hospital Services Commission is responsible for the capital financing and payment of operating costs for hospitals. However,

[1] Ibid., Page 37.

[2] Ibid., Page 37.

[3] Letter from John S. Sheriff, Executive Director, H.P.R.B., May 14, 1976 to the author. See Appendix 3.

control of hospital operating expenditures is undertaken by the Ministry of Health which reviews annual operating budgets.[1]

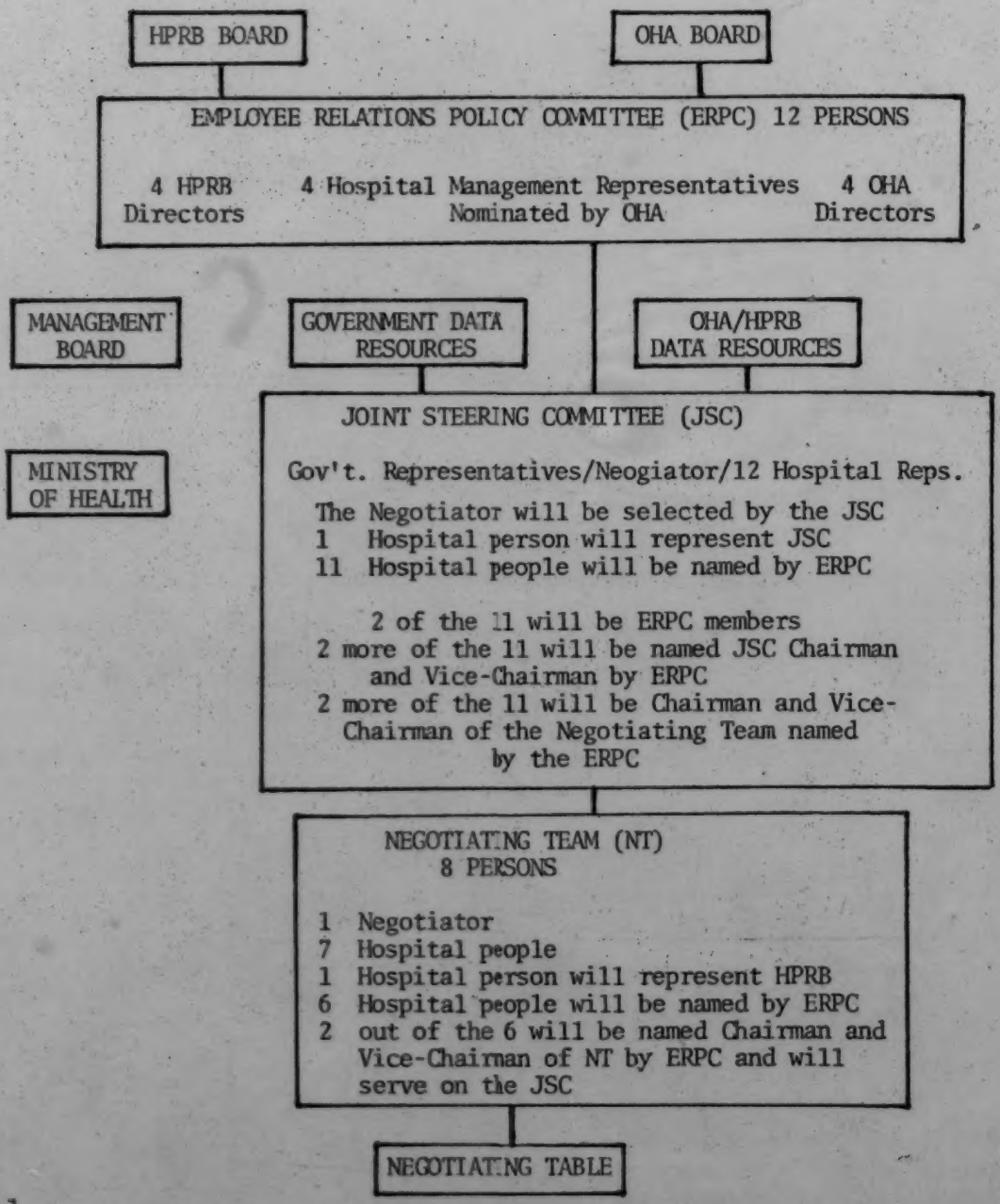
The recommendations of the Report of Hospital Inquiry Commission November 1974 include moving toward province-wide bargaining immediately.[2] As of May 1976, the organizational structure of collective bargaining on the management side reflects the plan recommended by the Commission.[3] That organizational plan is presented by Diagram 9.

[1] Alden, R.E., et.al., Op. cit., Page 13.

[2] Ibid..

[3] Ibid., Page 38.

Diagram 9 RECOMMENDED ORGANIZATIONAL PLAN FOR OHA/HPRB INPUT IN WIDE AREA OR PROVINCIAL NEGOTIATIONS[1]

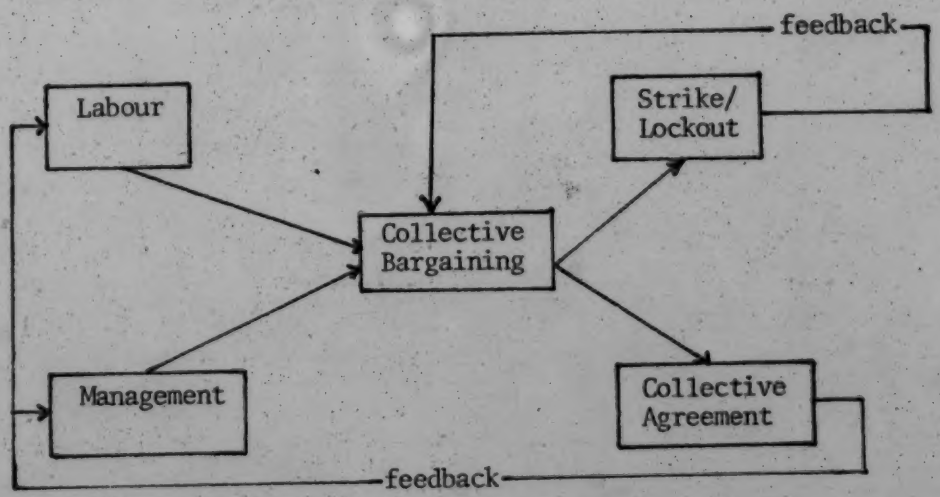

HPRB BOARD
OHA BOARD
EMPLOYEE RELATIONS POLICY COMMITTEE (ERPC) 12 PERSONS
4 HPRB Directors
4 Hospital Management Representatives Nominated by OHA
4 OHA Directors
MANAGEMENT BOARD
GOVERNMENT DATA RESOURCES
OHA/HPRB DATA RESOURCES
JOINT STEERING COMMITTEE (JSC)
Gov't. Representatives/Neogiator/12 Hospital Reps.
The Negotiator will be selected by the JSC
1 Hospital person will represent JSC
11 Hospital people will be named by ERPC
2 of the 11 will be ERPC members
2 more of the 11 will be named JSC Chairman and Vice-Chairman by ERPC
2 more of the 11 will be Chairman and Vice-Chairman of the Negotiating Team named by the ERPC
MINISTRY OF HEALTH
NEGOTIATING TEAM (NT)
8 PERSONS
1 Negotiator
7 Hospital people
1 Hospital person will represent HPRB
6 Hospital people will be named by ERPC
2 out of the 6 will be named Chairman and Vice-Chairman of NT by ERPC and will serve on the JSC
NEGOTIATING TABLE

[1] Alden, R.E., et. al., Op. Cit., Page 38.

COMPARISON OF THE CONVERSION MECHANISMS: (C)

This section will compare the employers' organizations in Alberta, British Columbia, and Ontario health care industries. In terms of Hameed's model the conversion mechanism is diagrammed as;

Diagram 10 CONVERSION MECHANISM



Organization Structure of Employers and Unions

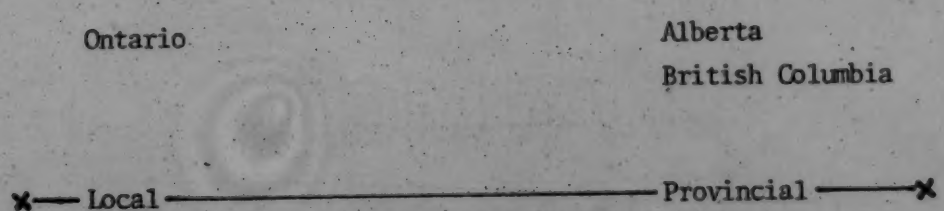
The first aspect discussed will be "Management", more specifically the structure of "Management", the employers' organization, will be discussed vis a vis the structure of "Labour" in each province. As Chapter III concluded, one aspect of the social system, namely union structure, appears to affect the structure of the employers' organization.

The union structure in each province, as presented in Chapter III, might be characterized as;

Alberta	- a combination of unions which operate virtually provincially and unions and other employee groups which operate in a limited number of institutions, e.g. pharmacists are employed only by larger institutions.
British Columbia	- vitually provincial unions.
Ontario	- a combination of unions which negotiate locally with a single institution, unions and other employee groups which negotiate on a regional basis, and in 1976 nurses virtually negotiating province-wide.[1]

These provinces could also be characterized by their repsective union structure by a continuum, the poles of the continuum being local union organization only and provincial union organization.

Diagram 11 CONTINUUM OF UNION STRUCTURE IN THE THREE PROVINCES



[1] See Appendix 3, letter from John S. Sheriff of the H.P.R.B.

The employers' organization described at the beginning of this chapter may be characterized by their structure just as union organization has been characterized by its structure;

Alberta - a single employers' organization, the A.H.A., negotiates with all hospital employee groups whether organized provincially or on some regional basis and as well provides other services to its member institutions.

British Columbia - an employers organization dedicated to health care labour relations, H.L.R.A., distinct from an organization providing other services to health care institutions, B.C.H.A.

Ontario - an employers' organization dedicated to health care labour relations for those institutions which care to utilize the service, H.P.R.B.; as well as a separate organization, O.H.A., which provides some labour relations services in addition to those of the H.P.R.B. and also provides services not related to labour relations.

These organizations might also be placed on a contiuum with the poles of the continuum being single organizations providing specialized services and multiple organizations providing labour relations services.

Diagram 12 CONTINUUM OF EMPLOYERS' ORGANIZATION STRUCTURE IN THE THREE PROVINCES

Alberta	British Columbia	Ontario
X—Single organization providing all services including labour relations	Single organization for labour relations, single organization for all other services	Multiple organizations providing labour relations services —X

There are additional factors characterizing the employers' organizations in each province, namely autonomy of member institutions and the Secretariat willingness to bargain.

Autonomy

Alberta

In Alberta, individual hospital autonomy has been jealously guarded. That is, individual hospital boards and administrations insisted on conducting their negotiations for fear of losing some of their management rights.[1] Over the past three years however, an evolutionary and educational process has relieved this fear. Hospitals are still very much involved in the bargaining process but their involvement is now on a cooperative rather than individual basis.

British Columbia

British Columbia hospitals have as of May 30, 1975 relinquished all collective bargaining responsibilities to the H.L.R.A. All autonomy in this area has been surrendered.[2]

[1] Alberta Hospital Association, Employment Relations Committee, Report on Provincial Labour Relations, 1975, Page 3.

[2] Health Labour Relations Association, Constitution, British Columbia, 1973, Page 12.

Ontario

Ontario hospitals are still highly autonomous relative to Alberta and British Columbia hospitals. A few urban hospitals are cooperating in collective bargaining but in general it's every institution for itself. For several reasons, the Report of the Hospital Inquiry Commission has recommended that provincial bargaining should ultimately occur.[1]

Secretariat Willingness to Bargain

Alberta

The Secretariat of the A.H.A. has been bargaining willingly on behalf of its members for some years. The A.H.A. Secretariat sees no conflict of interest in acting as the employers' bargaining agent and at the same time representing its member institutions in a number of policy matters.[2]

British Columbia

The Secretariat of B.C.H.A. is no longer involved in collective bargaining in the health care industry. Due to lack of expertise and perceived conflicts of interest, the British Columbia Hospital

[1] Alden, R.E., et.al., Op. cit., Page 41.

[2] Alberta Hospital Association, Op. cit., Page 11. Programmes supporting both negotiations with unions and negotiations or lobbying with government were identified as priorities in services to member institutions.

Association supported the establishment of the Health Labour Relations Association in May of 1975.[1]

Ontario

The Ontario Hospital Association set up a separate bargaining body almost immediately that collective bargaining agreements entered the health care field. The O.H.A. has not demonstrated any interest in providing provincial collective bargaining services. Such services are presently being provided by the Health Personnel Relations Bureau.[2] There has been some movement however to increase communication and cooperation between the O.H.A. and H.P.R.B. in recent months.

[1] These feelings were expressed to that author in informal discussion with delegates to the May 1975 meeting of the British Columbia Hospital Association held in Vancouver when the Constitution of the Health Labour Relations Association was approved.

[2] Alden, R.E., et.al., Op. cit., Page 36.

CONCLUSION

A contributing factor to the structure of the employers' organization is the structure of unions. It may be said that the major determinant affecting the structure of the employers' organization is in fact the structure of unions. The unions were, as Chapter III indicates, the first to organize. In Alberta, it was not until the late 1960's that the employers started to cooperate in collective bargaining. Unions had started organizing workers as early as 1917.[1] In contract, Ontario is still trying to organize both employer and employee groups.

[1] Interview with Murray Ross, Executive Director, Alberta Hospital Association.

Table 7 presents a summary of the comparison between union structure and employers' organization structure. Both Alberta and British Columbia have an employers' organization which is dedicated to industrial relations. Unions in Alberta and British Columbia are organized essentially provincially. In Ontario there are two employers' organizations both involved in industrial relations; and local, regional, and provincial union structures.

Table 7 SUMMARY OF THE COMPARISON BETWEEN UNION STRUCTURE AND EMPLOYERS" ORGANIZATION STRUCTURE

	Alberta	British Columbia	Ontario
Union Structure	provincial	provincial	local, regional and provincial
Employers' Organization Structure	single organization with a department dedicated to industrial relations	two organizations one dedicated to industrial relations	two organizations both involved in industrial relations

In British Columbia a distinct industrial relations organization has emerged, H.L.R.A., because B.C.H.A. felt that industrial relations was creating a conflict of interest within its organization. Similarly, Ontario has two employer groups - one to bargain collectively on behalf of its members and the other to represent its members to the provincial government. Alberta's employers' organization, the A.H.A., considers that there is no conflict of interest in one organization representing its member institutions on labour relations matters while at the same

time representing its members as a lobby group to various provincial agencies.

It would appear that conflict of interest as it is perceived by the organization contributes to the structuring of the organization. In other words, the A.H.A. feels comfortable in providing both collective bargaining services and other services such as government liaison. As Chapter V will indicate, the efficiency of the A.H.A. in collective bargaining is not hampered by its dual role as representative to government.

On the other hand, both British Columbia and Ontario have decided that for their respective employers' organizations there is a conflict of interest between collective bargaining and other services such as liaison with government which necessitates two employers' groups. The reasons for this perception of the conflict of interest in roles is not clear in any of the material researched by the author.

Autonomy and the willingness of the Secretariat to bargain may also contribute to some extent to the structure of the employers' organization in collective bargaining although they may actually reflect the historical development of the IR system.[1]

[1] The "Secretariat" is the permanent administrative office of an Association.

In Alberta and British Columbia, autonomy has been secondary to the collective interests of bargaining with unions because unions have been strong. In Ontario, hospital autonomy appears to be important perhaps partly due to the fact the union locals have some autonomy. The more important autonomy is to an institution or local, the more difficult it would likely be ot organize and submit to a third party responsible for collective bargaining.

Related to autonomy is willingness of the Secretariat to bargain. The Secretariat provides services which its membership demands. Autonomous members would not demand their Secretariat to take responsibility for collective bargaining. The demand for regional or province-wide negotiations would in part be a response to the structure of unions. If unions are structured province-wide, i.e., have relinquished local autonomy, they are in a more powerful position vis a vis the implications of the strike. If unions are powerful, then the employer must be powerful as well and this requires collective action. Autonomy and Secretariat willingness to bargain are also influenced by the structure of unions.

Equation (4) may now be represented as:

$O = f(I_1, I_2, I_3, E, C)$ where inputs have already been explained and E and C are as follows;

E = internal environment or the shared understanding amongst participants as a result of a unique hisotry, and

C = conversion mechanism.

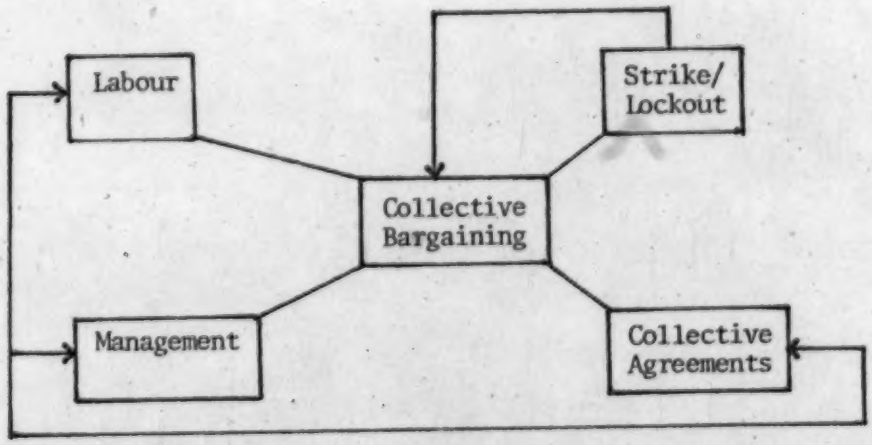
Alberta	- essentially provincial unions, and a single employers' organization;
British Columbia	- provincial unions, and two employers' organizations one of which provides industrial relations services;
Ontario	- local regional and provincial unions, and two employers' organizations both involved in providing industrial relations services.

CHAPTER V

COMPARISON OF THE OUTPUTS OF THE HEALTH CARE INDUSTRIES IN ALBERTA, BRITISH COLUMBIA, AND ONTARIO: (O)

The purpose of this chapter is twofold. First, to evaluate the organizational structure of the health care industry employers' organizations in Alberta, British Columbia, and Ontario vis a vis each organization's performance according to a set of criteria. Second, to assess the usefulness of Hameed's industrial relations model in analyzing industrial relations systems.

Notwithstanding the limitations imposed on evaluation [illegible]ia, this chapter considers selected outputs of the industrial relations systems and evaluates these outputs vis a vis inputs. Referring to Diagram 10, "Conversion Mechanism", i.e.



this chapter will deal with monetary items from collective agreements and other measurable outputs resulting from the process and attempt to evaluate these outputs vis a vis the inputs.[1]

There are a number of outputs resulting from collective bargaining e.g. non-monetary terms of agreement, strikes, lockouts, conciliations, mediations, arbitrations, and legislative reform all of which are measurable. There are other outputs which are not so easily measured. These include the attitudes and feelings of the negotiators, both labour and management, towards each other; the feelings of the rank and file towards their representatives; and the feelings of the public regarding the settlement and circumstances surrounding the settlement. Feelings and attitudes are difficult to measure and could be the subject of a thesis in themselves. The scope of this thesis is therefore limited to the following outputs of the industrial relations system; selected monetary items of selected agreements, strikes and mandays lost due to strikes, and the relative autonomy of individual hospitals. In other words, for purposes of analysis, the health care industrial relations system has been "closed".

[1] Statistical data on the number of conciliations, arbitrations, and mediations is not available.

EVALUATION OF THE STRUCTURES OF THE EMPLOYERS' ORGANIZATIONS

In evaluating organization structure, two dimensions of performance may be identified i.e. effectiveness and efficiency. Without differentiating as to which measures refer to effectivess and which measures refer to efficiency, because any differentiation would be arbitrary, the following criteria are used in evaluating the structures of each employers' organization;

- wage settlements i.e. cost to the employers,
- autonomy, and
- strikes.

Wage Settlements - Cost to the Employers

Three employers' association's collective agreements were selected in order to evaluate the health care industry employers' organizations. They are nurses i.e. in Alberta the A.A.R.N., in British Columbia the R.N.A.B.C., and in Ontario the O.N.A.; general service i.e. C.U.P.E., which is represented in all three provinces; and health sciences i.e. the H.S.A.A., in Alberta, H.S.A.B.C., in British Columbia, and selected professional groups from Ontario which correspond to health sciences professional associations in Alberta and British Columbia.[1] These groups were chosen because they exist in each province and represent three basic categories of health care workers i.e. nursing service,

[1] All data concerning collective agreements used in this chapter was provided by research staff of the Alberta Hospital Association.

general service, and professionals. Data on these groups was also more easily obtained than other employee groups. Although the provinces which are the subject of this thesis have been limited to Alberta, British Columbia, and Ontario, it is not to be inferred that the settlements reached in other health care industries in other provinces do not affect the settlements reached in the three provinces under discussion. In an open system, as the health care industrial relations system is submitted to be, inputs come from innumerable sources. Settlements reached in Saskatchewan impact on Alberta. Similarly, settlements in the Quebec health care industry affect Ontario, and settlements reached in California affect British Columbia.

Nurses - Staff Nurse Classification

Diagram 13 illustrates the relative standing of staff nurses salaries in the three provinces for the years 1971 to 1976.[1] To show the relative standing of the salaries the data are ranked in the following table.

[1] Data for Ontario nurses for 1971 and 1972 was unavailable as was the ending rates for 1974 and 1975.

Table 8 NURSES SALARIES, MONTHLY STARTING RATE AND ENDING RATE BY PROVINCE FROM 1971 TO 1976[1]

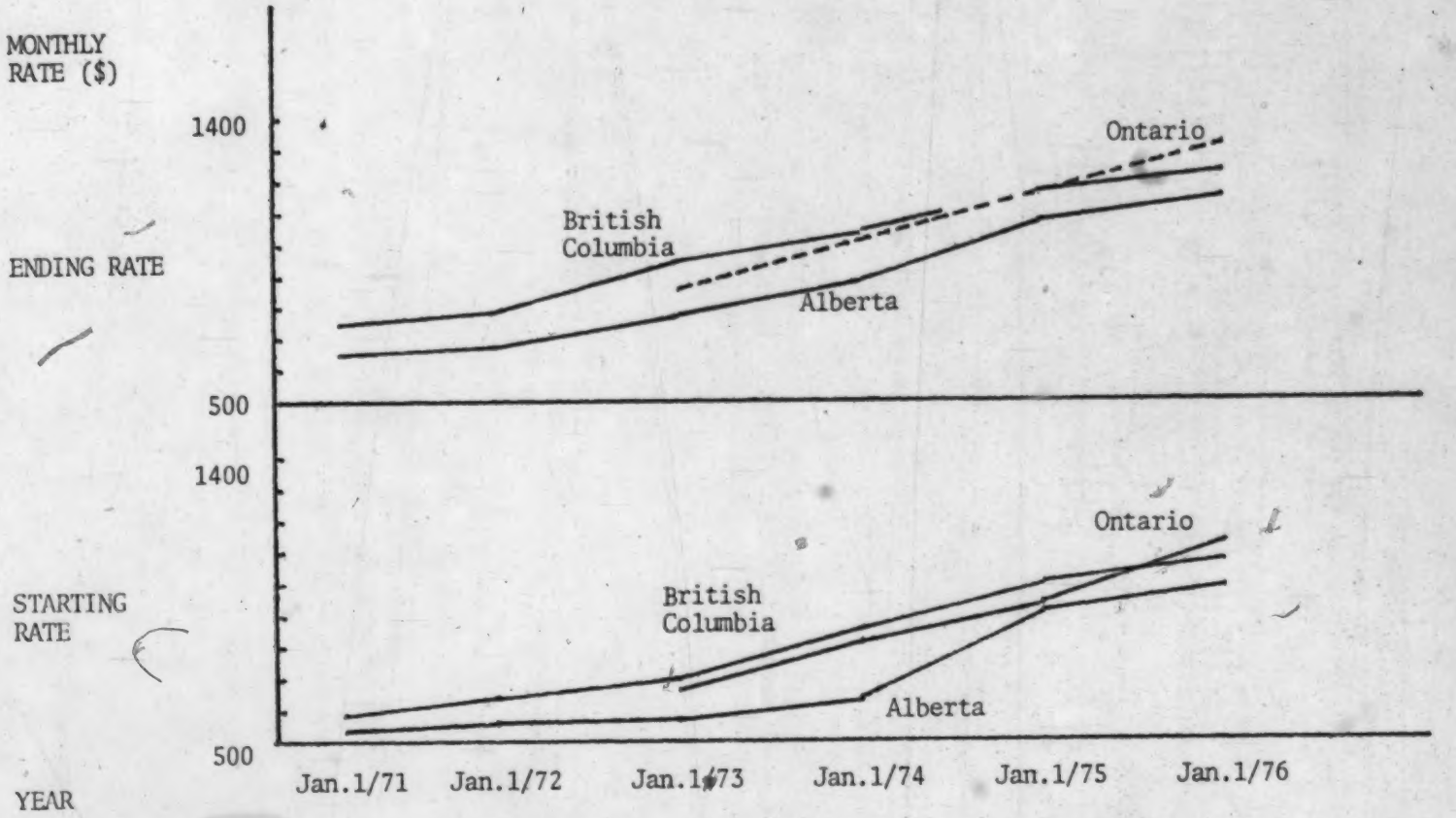
Starting Rate	1971	1972	1973	1974	1975	1976
Alberta	520 (1)	550 (1)	550 (1)	625 (1)	900 (1)	972 (1)
British Columbia	590 (2)	631 (2)	672 (3)	850 (3)	985 (3)	1049 (2)
Ontario	n/a	n/a	650 (2)	800 (2)	915 (2)	1115 (3)
Ending Rate						
Alberta	645 (1)	675 (1)	675 (1)	785 (1)	1075 (1)	1161 (1)
British Columbia	740 (2)	791 (2)	842 (3)	1020 (2)	1163 (2)	1239 (2)
Ontario	n/a	n/a	760 (2)	n/a	n/a	1315 (3)

The figures in brackets in Table 8 indicate the rank ordering of the starting and ending rates for each province from lowest (1) to highest (3) in cost. It can be seen that for both starting rates and ending rates Alberta was consistently lower in its nurses wages than the other two provinces. Considering the years 1973 to 1976, for which Ontario data was available, it can also be seen that British Columbia paid the highest starting rate to nurses until 1976 when Ontario surpassed the B.C. wage rate.

Diagrams 14, 15 and 16 provide further indication of the relative benefits negotiated by each province's employers' organization. Considering vacations with pay, Diagram 14, each province's vacation package might also be ranked from lowest cost to the employer (1) to

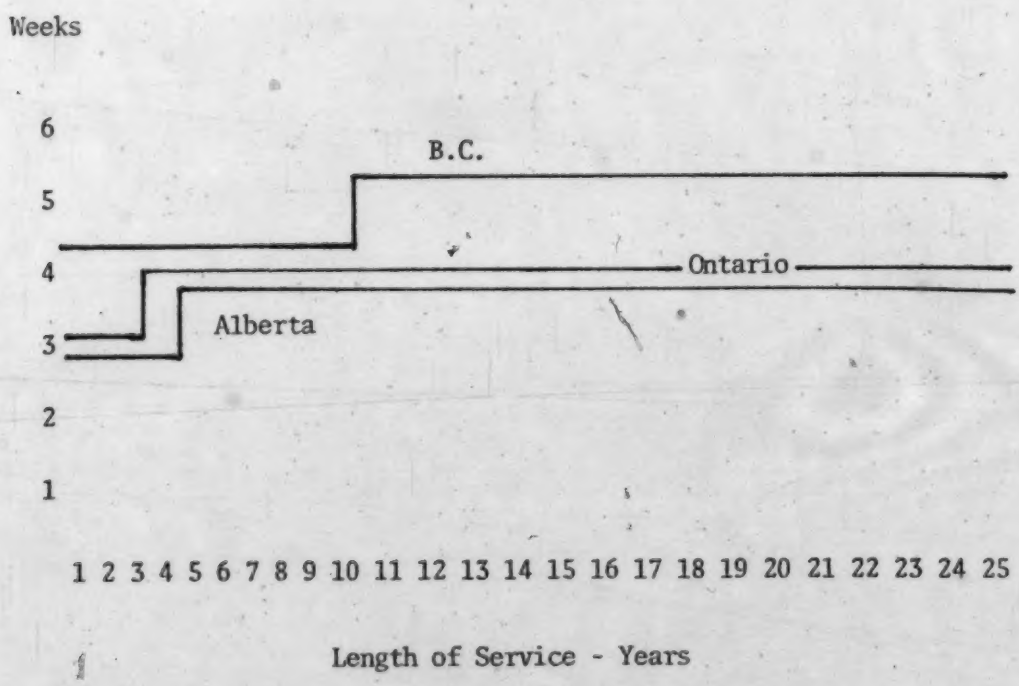
[2] Provided by A.H.A. research staff.

Diagram 13 NURSES' SALARIES, MONTHLY STARTING RATE AND ENDING RATE BY PROVINCE FROM 1971 TO 1976[1]



[1] The data in this diagram as with all data concerning wage settlements and benefits discussed in this chapter was provided by A.H.A. research staff from an internal A.H.A. document.

Diagram 14 VACATIONS WITH PAY - R.N.'S - BY PROVINCE FOR 1976[1]



[1] The data in this diagram was provided by A.H.A. research staff from an internal A.H.A. document.

Diagram 15 ON-CALL RATE - R.N.'S - BY PROVINCE FOR 1976

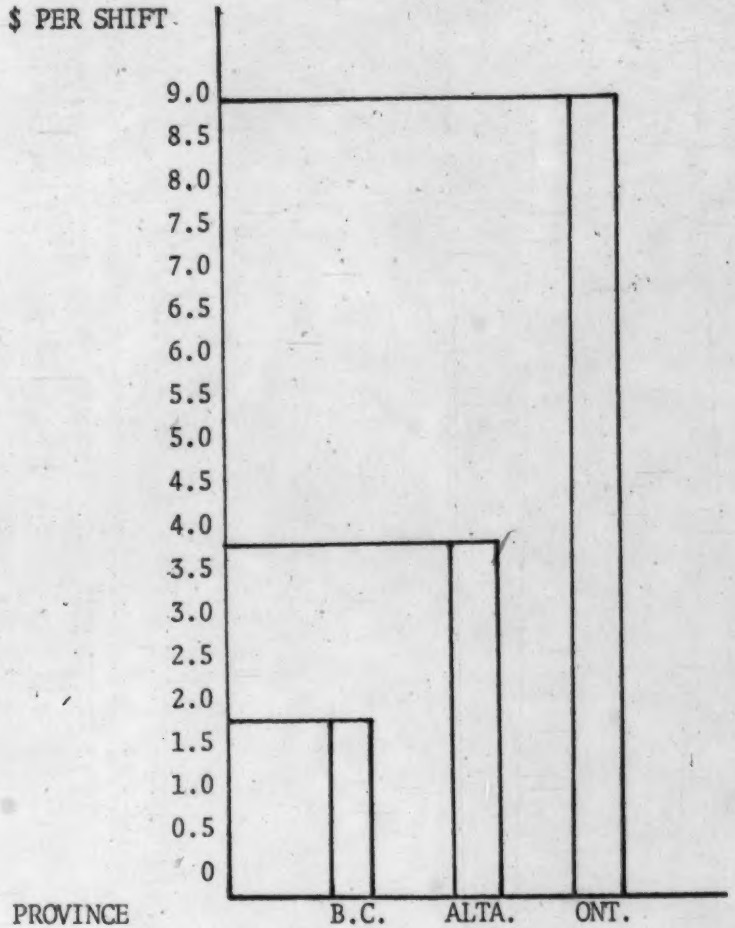
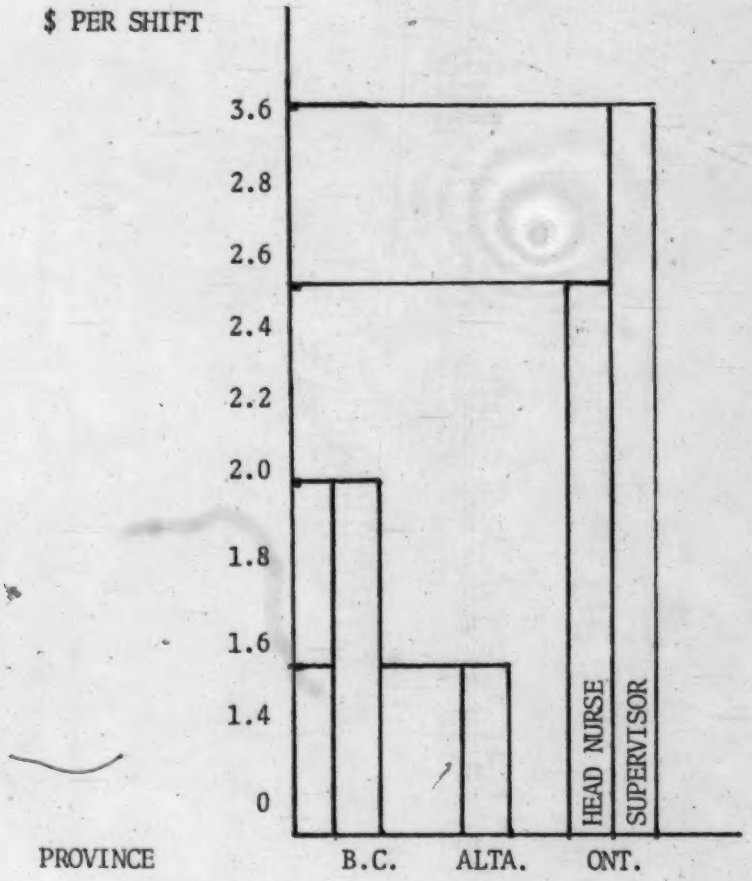


Diagram 16 RESPONSIBILITY ALLOWANCE - R.N.'S - BY PROVINCE FOR 1976 [1]



[1] The data in this diagram was provided by A.H.A. research staff from an internal A.H.A. document.

highest cost (3). The greater the number of weeks of vacations allowed the greater is the cost to the employer. In terms of the three provinces, British Columbia would rank number 3 as providing more weeks vacation for the same length of service and Ontario would rank number 2 as providing more weeks vacation for a lesser length of service than Alberta which would rank number 1.

Similarily with on-call pay, British Columbia would rank 1, Alberta 2, and Ontario 3 with the highest on-call rate. Responsibility allowance ranking of the three provinces results in Alberta with a rank of 1 with the lowest rate, British Columbia 2 and Ontario 3 with the highest rate. Table 9 summarizes the ranking for each aspect of the nurses collective agreement by province.

Table 9 RANKING OF SELECTED FACTORS OF THE NURSES COLLECTIVE AGREEMENTS BY COST TO THE EMPLOYER BY PROVINCE FOR 1976[1]

	Alberta	British Columbia	Ontario
Starting Wage Rate	1	2	3
Ending Wage Rate	1	2	3
Vacations With Pay	1	3	2
On-Call Rate	2	1	3
Responsibility Allowance	1	2	3

[1] A ranking of 1 is lowest cost to the employer.

General Service - Aide 1 Classification

Diagram 17 illustrates the relative standing of the Aide 1 C.U.P.E. classification in the three provinces for the years 1970 to 1976. This data is presented in Table 10 below where the starting rates and ending rates are ranked from lowest cost to the employer (1) to highest cost (3).

Table 10 C.U.P.E. SALARIES, MONTHLY STARTING RATE AND ENDING RATE BY PROVINCE FROM 1971 TO 1976[1]

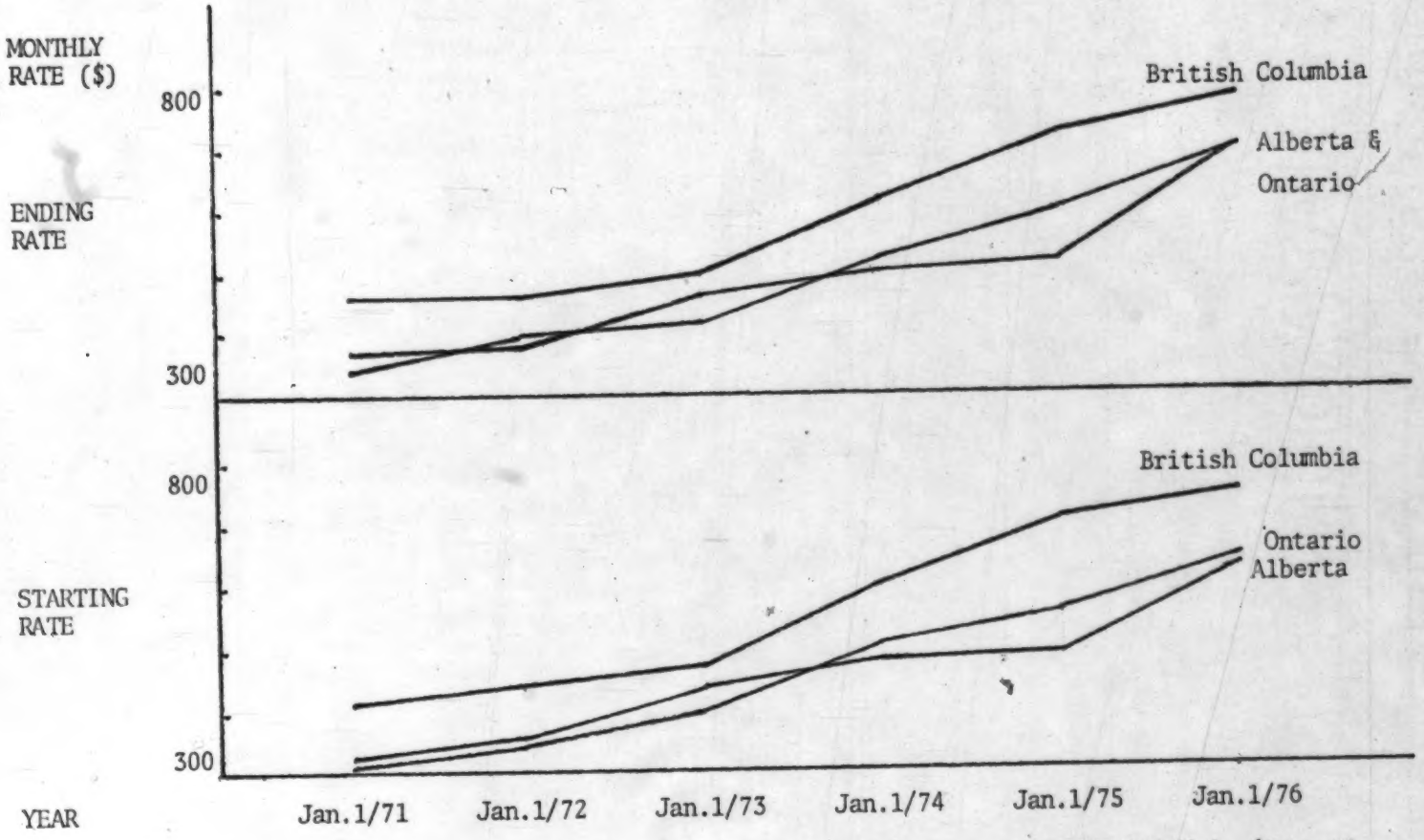
	1971	1972	1973	1974	1975	1976
Starting Rate						
Alberta	320 (2)	343 (2)	426 (2)	468 (1)	478 (1)	648 (1)
British Columbia	406 (3)	436 (3)	466 (3)	600 (3)	700 (3)	757 (3)[2]
Ontario	300 (1)	340 (1)	395 (1)	500 (2)	550 (2)	650 (2)
Ending Rate						
Alberta	364 (2)	389 (1)	462 (2)	504 (1)	514 (1)	700 (1)
British Columbia	433 (3)	463 (3)	493 (3)	630 (3)	730 (3)	788 (2)[2]
Ontario	330 (1)	395 (1)	435 (1)	530 (2)	600 (2)	700 (1)

For the years 1971 to 1973, Ontario generally ranked lowest, 1, in costs incurred by the employer for the Aide 1 category. British Columbia has been consistently highest with a ranking of 3 for the

[1] In British Columbia, the Hospital Employers Union, H.E.U., represents general service workers.

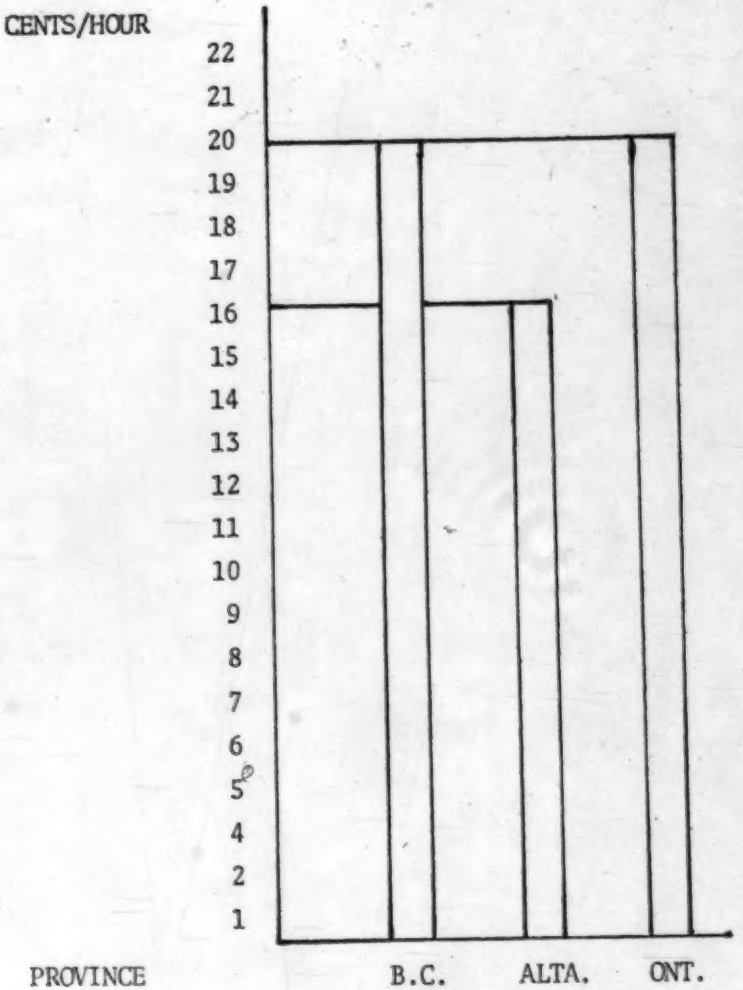
[2] H.E.U. has as of May 20, 1976, not settled in British Columbia but its 8% is added to the 1975 rates, the allowable increase under Anti-Inflation Board guidelines, then start and end rates for 1976 become $756 and $788 respectively.

Diagram 17 C.U.P.E. HOUSEKEEPING AIDE I SALARIES, MONTHLY STARTING RATE AND ENDING RATE BY PROVINCE FROM 1971 TO 1976[1]



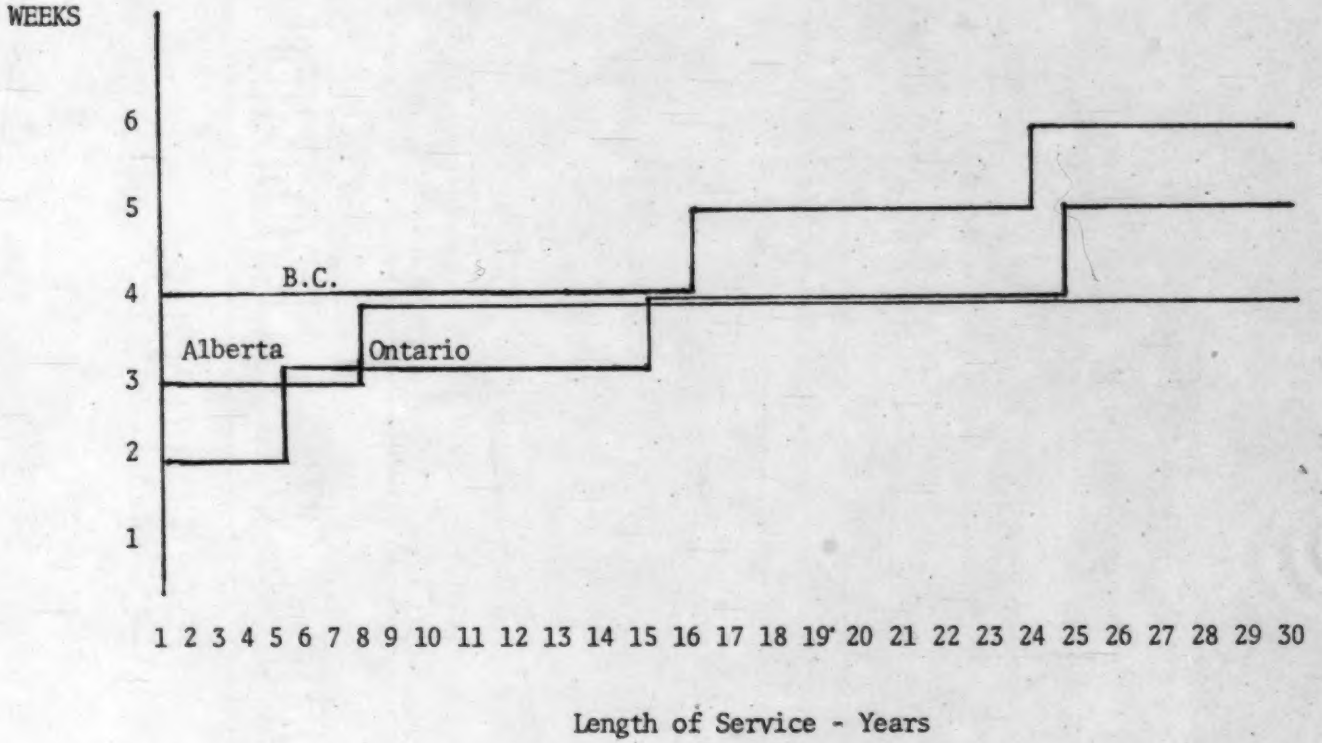
[1] The data in this diagram was provided by A.H.A. research staff from an internal A.H.A. document.

Diagram 18 SHIFT DIFFERENTIAL - C.U.P.E. - BY PROVINCE FOR 1976 [1]



[1] The data in this diagram was provided by A.H.A. research staff from an internal A.H.A. document.

Diagram 19 VACATIONS WITH PAY - C.U.P.E. - BY PROVINCE FOR 1976[1]



[1] The data in this diagram was provided by A.H.A. research staff from an internal A.H.A. document.

entire period of 1971 to 1976. In 1974, Alberta ranked lowest, as number 1, in costs of the Aide 1 classification starting and ending rates.

Diagrams 18 and 19 provide further indication of the relative benefits negotiated by each province employers' organization. Considering shift differentials, Alberta ranks lowest in cost to the employer at 16¢ per hour and British Columbia and Ontario are equal with a higher cost at 20¢ per hour. Similarly with vacations, British Columbia clearly ranks highest in cost to the employer for vacations with pay. Alberta ranks second in cost to the employer for the first five years after which time Ontario is either equal in cost to the employer or higher than Alberta. In order to determine actual costs to the employer, rather than relative costs, it would be necessary to know the number of staff in the Aide 1 category by length of service. Table 11 summarizes the ranking for each aspect of the C.U.P.E. agreement specifically the Aide 1 classification by province.

Table 11 RANKING OF SELECTED FACTORS OF THE C.U.P.E. COLLECTIVE AGREEMENTS BY COST TO THE EMPLOYER BY PROVINCE FOR 1976.

	Alberta	British Columbia	Ontario
Starting Wage Rate	1	3	2
Ending Wage Rate	1	2	1
Vacation With Pay	1	2	1
Shift Differential	1	2	2

Special Service - Technician 1 Classification

Diagram 20 illustrates the relative standing of professional salaries established by H.S.A. for the three provinces for the years 1971 to 1976. The relative standing, ranking, of the starting and ending rates is shown in Table 12 below.

Table 12 H.S.A. SALARIES, MONTHLY STARTING RATE AND ENDING RATE BY PROVINCE FROM 1971 TO 1976

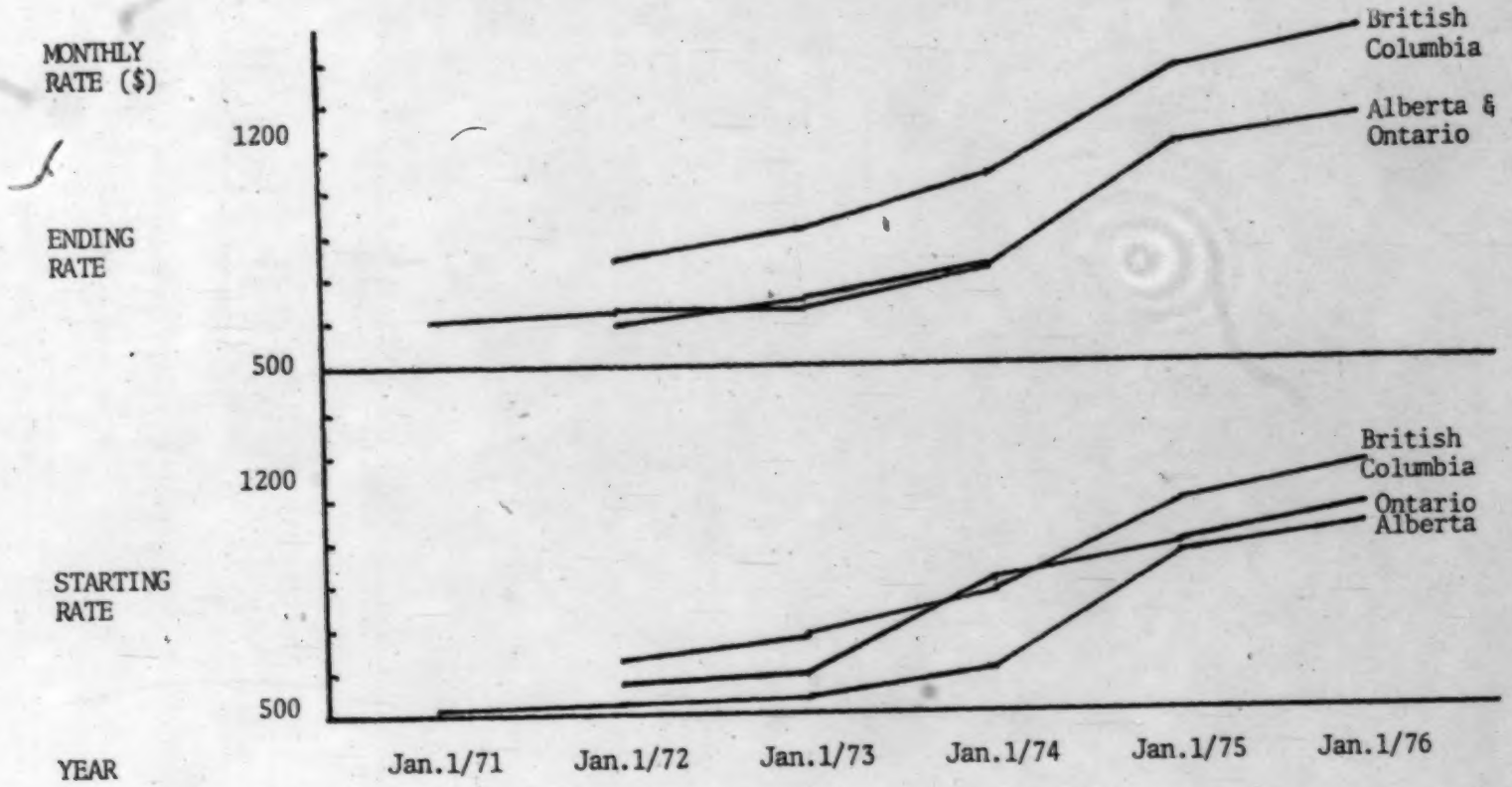
	1971	1972	1973	1974	1975	1976
Starting Rate						
Alberta	500	510 (1)	525 (1)	600 (1)	860 (1)	929 (1)
British Columbia	n/a	622 (3)	667 (3)	790 (2)	985 (3)	1064 (3)[1]
Ontario	n/a	554 (2)	588 (2)	797 (3)	875 (2)[2]	945 (2)[3]
Ending Rate						
Alberta	600	610 (2)	630 (1)	720 (1)	1000 (1)	1080 (1)
British Columbia	n/a	751 (3)	805 (3)	935 (2)	1182 (2)	1277 (2)[1]
Ontario	n/a	601 (1)	635 (2)	935 (2)	1000 (1)[2]	1080 (1)[3]

[1] H.S.A. wages are in arbitration as of May 18, 1976. If 8% is added to the 1975 rates then starting rates and ending rates becomes $1064 and $1271 respectively.

[2] These rates are April 1, 1975 rates. January rates were unavailable.

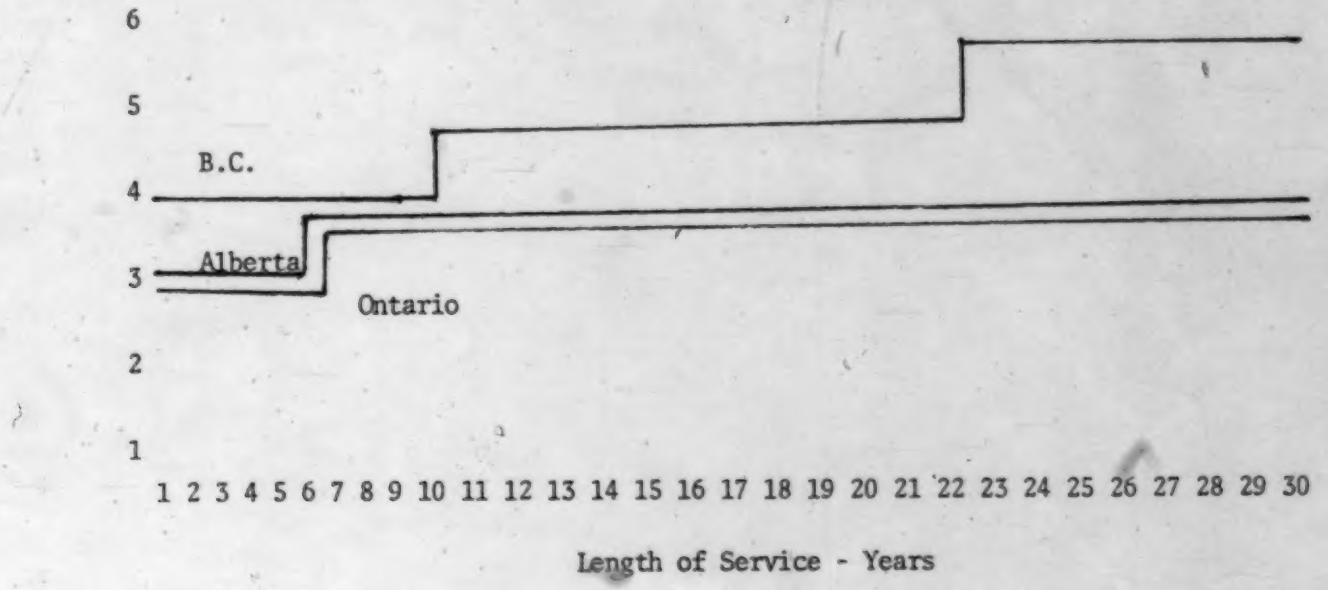
[3] The 1976 rates have not been settled as of May 18, 1976, but, if 8% allowable under Anti-Inflation Board guidelines is added to 1975 rates, then 1976 starting and ending rates becomes $945 and $1080 respectively.

Diagram 20 H.S.A. SALARIES, MONTHLY STARTING RATE AND ENDING RATE BY PROVINCE FROM 1971 TO 1976[1]



[1] The data in this diagram was provided by A.H.A. research staff from an internal A.H.A. document.

Diagram 21 VACATION WITH PAY - H.S.A. - BY PROVINCE FOR 1976 [1]



[1] The data in this diagram was provided by A.H.A. research staff from an internal A.H.A. document.

Diagram 21 indicates that with vacations, British Columbia provides greater benefit to employees than either Alberta or Ontario. With four weeks vacation after one year of service, British Columbia ranks 3 or the highest cost to the employer. Alberta ranks 2 because greater benefits, four weeks vacation, are provided after five years of service than are provided in Ontario. Table 13 summarizes the ranking for aspects of the H.S.A. agreement discussed.

Table 13 RANKING OF SELECTED FACTOR OF THE H.S.A. COLLECTIVE AGREEMENT BY COSTS TO THE EMPLOYER BY PROVINCE FOR 1976

	Alberta	British Columbia	Ontario
Starting Wage Rate	1	3	2
Ending Wage Rate	1	3	2
Vacation With Pay	2	3	1

It can be seen from the ranking of both starting and ending rates that Alberta has, with the exception of the ending rate for 1972, incurred the lowest cost to the employer i.e. a ranking of 1. British Columbia has incurred the highest cost to the employer in the Technician I classification under the H.S.A. agreements for the years 1972 to 1976 with the exception of 1974 starting rate.

SUMMARY

Within the scope of this thesis; i.e. not taking into consideration factors such as workload, productivity, and cost of living which affect the "real" wage to the employee and the "real" cost to the employer, an overall rank in terms of wage costs in the health care system may be calculated for each province.

A weighted ranking is calculated from the percentage of nursing, general, and special service personnel. The weighting factors are derived from Table 4 in Chapter 1, the percentage of total hospital personnel of nursing, general, and special service staff.

Table 14 WEIGHTING FACTORS BY SERVICE BY PROVINCE

	Nursing Service	General Service	Special Service
Alberta	.496	.309	.101
British Columbia	.476	.332	.114
Ontario	.470	.310	.133

As Table 4 in Chapter 1 indicates, 49.6% of all hospital staff in Alberta were employed in nursing service. The weighting factor thus is .496 for nursing service contribution to costs and in the calculation of the overall rank of the provinces in their total employee costs. Similarly, 30.9% of all personnel employed were general service staff in Alberta and the weighting factor here becomes .309. All weighting factors were derived in the same manner.

The calculation of the overall rank is made by adding the rank of the starting and ending wage rates and dividing by 2 to obtain an average wage rank. The Alberta nursing service this calculation is;

$$\frac{1 + 1}{2}$$

This average wage rank is then weighted by the percent of total employees in nursing service. For Alberta nursing service this becomes;

$$\frac{1 + 1}{2} \times .496$$

The average weighted ranks for other services are calculated in a similar fashion. The overall weighted rank is the sum of all the weighted ranks by service. For Alberta the overall rank becomes .91.

The overall rank for wage costs to the employer, a weighted average of the ranking of start and end rates are;

for Alberta

nursing service	+	general service	+	special service	
$\frac{1+1}{2} \times .496$		$\frac{1+1}{2} \times .309$		$\frac{1+1}{2} \times .101$	= .91

Table 15 OVERALL RANKING OF COSTS TO THE EMPLOYER

	Alberta				British Columbia				Ontario			
	NS[1]	GS	SS		NS	GS	SS		NS	GS	SS	
Starting Rate	1	1	1	.91[2]	2	3	3	2.12	3	2	2	2.14
Ending Rate	1	1	1		2	2	3		3	1	2	
Vacations	1	1	2		3	2	3		2	1	1	
On Call Rate	2	1			1	2			3	2		
Responsibility Allowance	1				2				3			

[1] NS = Nursing Service, GS = General Service, SS = Special Service

[2] Overall rank of starting and ending wage rates as calculated.

for British Columbia

nursing service	+	general service	+	special service	
$\frac{2+2}{2}$ x .476		$\frac{3+2}{2}$ x .332		$\frac{3+3}{2}$ x .114	= 2.12

for Ontario

nursing service	+	general service	+	special service	
$\frac{3+3}{2}$ x .470		$\frac{2+1}{2}$ x .310		$\frac{2+2}{2}$ x .133	= 2.14

Table 15 presents a summary of all items ranked including the overall ranking of start and end wage rates just calculated. From the table it can be seen that Alberta is lowest in wage costs to the employer. British Columbia and Ontario are about equal and higher than Alberta. Concerning vacations with pay, Alberta and Ontario are lowest in their benefits. Ontario has the highest on-call rates and responsibility allowance.

From the employers' organization viewpoint, it is advantageous to keep costs at a minimum. The preceding section has indicated that the province which has been most successful in achieving lowests costs for the classifications which were selected for analysis has been Alberta. One might say then that a single organization is most efficient and effective in negotiations with unions. However, some of the highest costs to the employers were found in British Columbia

which also has a single employers' organization. It would appear, that there are other factors influencing the effectiveness and efficiency of collective bargaining than just the organization structure of the employers' group. Further investigation and analysis perhaps using Hameed's open system model might provide insight.

Autonomy

The perception of autonomy and the manifestation of the perception of autonomy may be considered as an output of the collective bargaining process. Autonomy however is often not explicitly recognized as an output because it is not something which is "brought to the table". In Chapter II it was stated that just as there are tangible outputs such as wages, so there are intangible outputs such as feelings, attitudes, and perceptions. It is the perception of and attitude toward autonomy, an intangible output, which often changes as the result of the collective bargaining process. If during independent collective bargaining processes, two individual health care institutions discover that they are affecting each other's agreement, perhaps through "whipsawing" by the union, it is probable that their perception of their relative autonomy will change. The two institutions might even bargain together during the next round of negotiations. At the very least, when they approach the next negotiations it would not be without considering the effect of the other institution. The perception of autonomy has changed as a result of the collective bargain process. Autonomy is an output of the process.

Autonomy is also an input however because the relative autonomy of all the institutions affects the manner in which they organize for collective bargain. Highly autonomous institutions would bargain independently. Institutions which perceived their autonomy differently might bargain jointly. In other words employers' organization structure will be affected by the members perception of autonomy and will therefore affect, an an input, however employers face unions at the table i.e. as a unified group or as independent autonomous institutions.

In discussion with trustees, administrators, and personnel directors, individual employers autonomy is considered essential vis a vis the right of management to operate effectively and efficiently the institution for which it is responsible.[1] These responsibilities of trustees and administrators are defined in law in each provincial hospital act.[2] Similarly, the employers'

[1] Autonomy in administration of the contract is identified as part of the role of each institution in the Employement Relations Committee Report on Provincial Labour Relations to the Alberta Hospital Association, Op. cit., Page 5.

[2] Revised Statutes of Alberta 1970, The Alberta Hospital Act, Op. cit., Part 2, Page 15.

Revised Statutes of British Columbia, Hospital Act, Op. cit., Part 1, Page 1799, and the Hospital Act Regulations, Op. Cit., Regulation 729, Page 62.

Revised Statutes of Ontario, The Public Hospitals Act, Chapter 378, December 1974.

organizations consider essential to effective negotiations their autonomy in bargaining collectively on behalf of their member institutions.[1] As an evaluation criterion, autonomy takes into consideration the appropriate responsibilities of the actors i.e. government, employer and employee associations, and individual institutions.

Alberta

It is explicitly recognized by the A.H.A. that member institutions have final authority in administering the collective agreements, that it is the administration of each institution which must deal on a day-to-day basis with employees.[2] The employers' organization, the A.H.A., has defined its role according to the needs of its members and includes collective bargaining, grievance handling, and public relations.[3] To date there has been no government intervention into the Alberta health care industry. It might be said that there exists clear lines of responsibility and little fear of loss of autonomy in the Alberta health care industry.

British Columbia

With regard to British Columbia, the H.L.R.A. requires its

[1] Employer organization autonomy and privy of information is considered essential by the A.H.A. Employee Relations Committee, Report on Provincial Labour Relations, Op. cit., Page 4 and Appendix 4, Section 1.1 (b).

[2] Alberta Hospital Association, Employment Relations Committee, Op. cit., Page 5.

[3] Ibid..

members to appoint the H.L.R.A. as the sole agent "to conclude and execute all collective labour agreement," "to interpret and administer all such agreement," and "to negotiate, conclude, and execute all agreements for the settlement of any dispute arising out of any such collective agreement or the negotiation, interpretation, or administration thereof."[1]

It must be pointed out however that the H.L.R.A. interpretation of "execute" and "administer" has not been established but the emphasis of H.L.R.A. is on centralized control whereas Alberta and Ontario employers' organizations are more cooperative. In British Columbia it might be said that autonomy is uncertain as are the roles of institutions vis a vis the H.L.R.A.

Ontario

In Ontario, the employers' organization is searching for its proper role. The O.H.A. and H.P.R.B. have just initiated joint consultation in collective bargaining. The hospitals are however still concerned with their autonomy and this may make organization provincially more difficult for the O.H.A. and H.R.P.B. than it might otherwise be. John Sheriff of the H.P.R.B. summarized the continuing importance of hospital autonomy in Ontario.[2]

[1] Health Labour Relations Association, Constitution, British Columbia, 1975.

[2] See Appendix 3.

> "The lack of an accredited bargaining agency for hospitals and a council of trade unions has another effect, namely that uniform interpretation of collective agreements is still an objective to be achieved in the future. While the simplistic approach of Johnston to this matter sound appealing, there are obvious problems where individual hospitals treasure their own autonomy, and do not take kindly to the thought of having every detail of their collective bargaining agreements centrally administered as well as centrally negotiated. This would leave them with little individuality of their own. This may be a reactionary approach, but it is a natural one and a considerable educative process would be involved toward central administration. It needs to be seen in perspective, because central bargaining is concentrated on central issues (predominately, but not exclusively monetary) and local issues are still bargained locally at the individual hospitals, thus preserving their autonomy in matters which reflect their own individuality. Notwithstanding this the pressure of arbitration awards relating to very similar contracts does not tend to force upon hospitals a similar interpretation of contractural language and the trend can thus be seen to have already set in towards centralized administration and interpretation."

The autonomy of individual institutions is of great concern to the institutions themselves. The question of who should be responsible for health care collective bargaining i.e. a single organization, regional organization, or each institution, appears most alive in Ontario.

Summary

In Alberta, the autonomy of the individual institution has been of concern but an educational process directed to administrators and trustees of these institutions by the A.H.A. has gone a long way in alleviating their fears of loss of autonomy. The importance of education in this area was also stated by John Sheriff of the H.P.R.B.[1]

[1] See Appendix 3.

In the past in British Columbia however there has been some question by the individual institutions as to the effectiveness of the employers' organization hence the emergence of the H.L.R.A. A confusion in the role of the employers' organization vis a vis the individual institution with respect to industrial relations could result in an organization which is less effective than it might otherwise be. An organization which is less effective than it might be could also be expected to incur higher costs. Considering the defined autonomy of institutions and employers' organizations as an evaluation criteria, a clear definition of role and hence autonomy would lead to effectiveness. It would appear that Alberta has a clear definition of the role and area of autonomy of both the employers' organization and individual health care institutions in terms of documentation and shared understanding amongst all participants including unions and government. Although British Columbia has documented the role of the H.L.R.A. it must be questioned to what extent an employers' organization can administer a collective agreement.[1] One might say there is potential for confusion amongst participants. In Ontario both institutions and employers' organizations are attempting to define their respective roles. It would thus appear that Alberta has clear roles and areas of employer and employers' organization autonomy and British Columbia and Ontario less clear roles.

Strikes

Although there is no published information available regarding

[1] H.L.R.A., Constitution, Article V-1, Page 12.

strikes in the health care industry, the following unpublished data was available.

Table 16 STRIKES IN THE HEALTH CARE INDUSTRY BY PROVINCE FOR 1972, 1973, 1974 and 1975[1]

	Alberta	British Columbia	Ontario
Total man-days based on 1972 data of full-time staff	8.1 million	8.3 million	36.7 million
1972 Strikes	0	2	2
Man-days lost	0	1,520 (.0002%)	7,880 (.0002%)
1973 Strikes	1	0	1
Man-days lost	35,310 (.004%)[2]	0	1,890 (.0001%)
1974 Strikes	2	1	9
Man-days lost	1,300(.0002%)	1,010 (.0001%)	6,170 (.0002%)
1975 Strikes	6	1	4
Man-days lost	16,000 (.002%)	2,400 (.0003%)	10,870 (.0003%)

[1] Data was provided by Wally Gloeckler of the Federal Department of Labour. The strikes indicated include both legal and wildcat strikes in active treatment diagnostic facilities.

[2] Man-days lost expressed as a percent of total man-days. Man-days were calculated using the latest personnel data available in 1972. Man-days lost for 1973, 1974, 1975 were not calculated because Statistics Canada personnel figures are available for only 1972. Man-days lost for 1973, 1974, and 1975 are therefore assumed to be the same as for 1972.

The 1973 Alberta strike indicated in Table 16 occurred at the Royal Alexandra Hospital in Edmonton when C.U.P.E. legally withdrew their members for the period from June 11 to July 30. The Royal Alexandra Hospital conducted its own negotiations with C.U.P.E. during 1973. The hospital did not participate in provincial negotiations that year but did so in 1975 when the two year 1973 contract terminated.[1] Of the six strikes in Alberta in 1975, five of those were wildcat. There is no information available for British Columbia and Ontario concerning the type or circumstances of the strikes between 1972 and 1975.

For all three provinces, the proportion of man-days lost due to legal and wildcat strikes is negligible compared to the total man-days worked. Using 1972 figures from Table 4 in Chapter 1 for the number of full-time personnel only, Ontario had approximately 36.7 million man-days worked (100,557 full-time employees x 365 days), Alberta had approximately 8.1 million man-days worked (22,328 x 365 days), and British Columbia had approximately 8.3 million man-days worked (22,784 x 365 days).[2] Other than the fact that man-days lost due to legal and wildcat strikes is a trivial proportion of the total man-days worked, there appears to be little that can be inferred from the data. Ontario appears to have the odd, short-lived strike every

[1] Interview with Leo Lancaster, Negotiator, Alberta Hospital Association.

[2] Estimates are based on 1972 data - the latest available - presented in Table 4 Chapter 1.

year. British Columbia similarly has had a history of few strikes, at least in the health care industry, and it appears that the H.E.U. had not withdrawn its members during the 1972 to 1975. Total man-days lost due to strike, had H.E.U. struck, would have been in the tens of thousands since their membership is well over eleven thousand members. More information on the circumstances of each strike would be necessary before their relationship, if any, to the employers; organization could be determined.

Summary

Equation (4) may be written in terms of two of the factors which form the basis of the evaluation; terms of agreement, and autonomy. More information concerning strikes is requires before an evaluation using strikes and man-days lost could be meaningful.

O = terms of agreement and wage settlements for selected nursing service personnel, general service personnel, and professional personnel; and autonomy of member institutions within the health care industry, their feelings and attitudes towards their employees.

O Alberta = .91 and clear autonomy of institutions and employers' organizations.

O British Columbia = 2.12 and less than clear autonomy of institutions and employers' organizations.

O Ontario = 2.14 and clear autonomy of institutions and employers' organizations.

The three provinces are thus ranked according to the efficiency of their health care industrial relations systems. Alberta is most

efficient and effective as measured by cost to the employer and employer autonomy. Ontario and British Columbia are less efficient compared to Alberta in terms of cost to the employer which perhaps is more important to employers in the long run than is the maintenance of autonomy. The overall ranking would therefore be;

Alberta	1
Ontario	2
British Columbia	2

with a ranking of 1 being most efficient and effective.

EVALUATION OF HAMEED'S INDUSTRIAL RELATIONS MODEL

To summarize, Hameed's Industrial Relations Model is an open systems model specifically directed to industrial relations. The application for organization and management of general systems theory has been discussed by Kast and Rosenzweig.[1] The authors discuss dilemmas which arise in utilizing systems concepts and the difficulties of not completely understanding organizations as total systems. One particular problem in utilizing general systems theory which Kast and Rosenzweig discuss is that

> "we know (or think we know) more about certain relationships than we can fit into a general systems model. For example, we are beginning to understand the two-variable relationships between technology and structure. But when we introduce another variable, say psychosocial relationships, our models become too complex. Consequently, in order to discuss all the things we know about organizations, we depart from a systems approach. Perhaps it is because we know a great deal more about the elements of subsystems of an organization than we do about the interrelationships and interactions between these systems. And, general systems theory forces us to consider those relationships about which we know the least - a true dilemma. So we continue to elaborate on those aspects of the organization which we know best - a partial systems view."[2]

With respect to Hameed's model and its application to the health care industry, this dilemma has also occurred. In analayzing organizations,

[1] Kast, F.E., and Rosenzweig, J.E., "General Systems Theory: Application for Organization and Management," Academy of Management Journal, December 1972.

[2] Ibid., Page 454.

specifically industrial relations organizations, the author has focused on the interrelationships and interactions between actors i.e. the relationship between unions and their development and structure, and employers' organizations and their structure. It is one thing to define these and other inputs, e.g. social, economic, political and legal factors as was done in Chapter III, but describing their interactions and resulting outputs in "systems terms" becomes increasingly complex with the number of variables to be considered. The characteristic of systems theory, "equifinality", which states that an outcome may be attained through a variety of means, further complicates a systems analysis and evaluation for it can no longer be suggested that there is a single appropriate industrial relations system for the health care industry. Rather, there may be many alternatives open to the actors in achieving acceptable outputs. Because of the complexity and relative infancy of the application of systems theory to organizations, the author has attempted to explore the relationship between a limited set of factors, i.e. union structure, and employers' organization structure. The author found in using Hameed's model that the focus of the model is on "relationships" between components rather than just the components alone proved most useful. As Kast and Rosenzweig stated, systems theory forces us to consider those relationships about which we know the least.

CHAPTER VI

CONCLUSION

This report has addressed two questions. First, what are the structural or organizational determinants affecting the manner in which employers in the health care industry organize for collective bargaining. It was found that union organization and the perception of conflict of interest appear to be influential factors. When the three employers' organizations were evaluated to determine which was the most effective and efficient, using monetary factors, a single employers' organization in Alberta was found to incur the lowest cost to the employer. Where there was more than one employers' organization, British Columbia and Ontario, the cost to the employer increased.

When autonomy was considered, it was found that the perception of autonomy affected organization structure. At one extreme, Ontario's organization of employers was found to be fragmented due to the clearly independent nature of individual institutions. At the other extreme, Alberta's organization of employers was found to be cohesive due to a clear definition of the role, and hence area of autonomy, of individual institutions. To reiterate, Alberta's health care costs were found to be lower than those in Ontario and British Columbia.

It may therefore be concluded that fragmentation of the employers leads to greater cost to the health care system. Conversely, it may be stated that when employers cooperate and maintain effective control over collective bargaining, health care costs are minimized. Although British Columbia employers cooperate in collective bargaining, it is questionable to what extent they actually affect or control the collective bargaining process. Their interests have been relegated to third party professionals and their costs have also exceeded those in Alberta.

An indicator of the relationship between unions and employers which also reflects the efficiency and effectiveness of the employers' organization is the examination or lack of examination by government agency or appointee. British Columbia and Ontario health care industries have experienced third party examination. In Ontario is was R.E. Alden and in British Columbia it was R.D. Blair who made recommendations concerning collective bargaining in the health care industry. Third party evaluation of the collective bargaining processes in Ontario and British Columbia, reflects either an unwillingess or inability of the parties to deal with their own affairs. To date, the Alberta health care industry has operated sufficiently and efficiently and there has not been the need for third party intervention into the relationships and organization of the parties as in British Columbia and Ontario. There is something to be said for organizations which can work efficiently together.

The second question addressed itself to the usefulness of open systems theory specifically Hameed's model of industrial relations to the analysis of industrial relations and evaluation of employers' organizations in the health care industry. The author concurs with Katz and Rosenzweig that an open systems approach focuses on the interrelationships between subsystems, those aspects of organizations about which we know the least. The open systems model must be used within defined limits for analysis to tbe possible. That is, the scope is necessarily limited and the factors under analysis, i.e. inputs and outputs, are also limited to those for which data is available and measurable.

Kast and Rosenzweig make two other comments significant to this thesis. First, they distinguish between organization and an "Organization". An "Organization" consists of elements which have and which can exercise their own wills. It is significant because the industrial relations system in the health care field is an organization of purposeful entities.[1] In a complex world organized of many purposeful entities, we need to be able to understand and predict relationships between sub-systems. This is the second comment of significance, that we need general systems theory but "we are not sufficiently sophisticated to use it appropriately. This is the dilemma."[2]

[1] Kast and Rosenzweig, "Op. cit.", Page 453.

[2] "Ibid.", Page 458.

The model provides a method of comparing similarities as well as differences. Although the provinces on first glance may appear similar, there are certain differences which become apparent upon closer examination. Similarities exist in the social structure and the adversary nature of the relationship between employer and employee groups and in the economic system of universal medical care. Differences exist in political philosophy, legislation, and historical development including the structure of unions and employers; organizations. It is useful to have differences as well as similarities illustrated for differences can provide the direction for further research.

Further analysis using Hameed's model could provide insight on the effect of variety of outputs feeding back into the system. It should be possible to study the dynamic inter-relationships of the health care industrial relations system using Hameed's model. The author concludes that Hameed's model is indeed useful for organizational analysis in industrial relations and should provide a useful framework for further analysis in industrial relations.

Suggestions for Further Research

In British Columbia and Ontario, a second employers' organization was formed to negotiate collective agreements. This organization, devoted to labour relations, would ostensibly have greater freedom in union negotiations because it would not find it necessary to consider their actions against any criteria other than obtaining the best possible contract for its members. In other words, the inference maybe drawn that

this labour relations employers' organization need not be concerned with how the negotiated agreement affected the delivery of health care because health care standards and policy were matters of concern for the employers' professional association. The author finds this rationalization for a separate labour relations organization somewhat difficult to swallow. The institutions which make up the labour relations organization are the same institutions which make up the professional association and one wonders what real difference is made when it appears that all that the member institutions are doing, vis a vis their two employers' organization, is "changing hats".

It is difficult, especially in times of financial constraints, to separate the negotiation of the collective agreement with standards of quality in the delivery of health care and the interest of the paying agency, the government Ministry responsible for the allocation of public funds to health care. The author suggests that these questions are interrelated and should be dealt with by one organization only so that the issues and dilemmas are met and workable solutions attempted.

The danger inherent in an organization dedicated to labour relations and separated from the professional association is that the responsibilities of the labour relations "arm" can easily be relegated to the paid, full-time, negotiators who are the employees of the organization. In Alberta, negotiating teams are comprised of knowledgeable experienced individuals on a volunteer basis and a full-time negotiator, an employee of the organization, who acts as

spokesman and resource. The individual institutions however are responsible for the negotiations. That is, the members are responsible for ensuring that the negotiated agreement reflects their wants and demands.

At the other extreme, the Health Labour Relations Association of British Columbia relies on full-time negotiators who exert much more influence on the final agreement than does the membership. Many of the details of negotiations and necessary compromises made at the table are thus not appreciated not understood by the membership.

The author recognized that labour relations and collective bargaining have reached a sophistication which necessitates professional guidance and expertise, however the necessity for professionalism and expertise should not undermine the equally important necessity for employers to be responsible for the setting of conditions under which their employees will work and which will affect the day-to-day administrations of the institution. The author therefore concludes that a single organization should provide both labour relations and other services for its members and further that the concept of volunteer involvement in negotiating teams be maintained and encouraged as a valuable means of communication and a real vehicle for meaningful participation. The author suggests however that further research into the role and appropriate organization structures of employers in the health care industry for purposes of collective bargaining relating to policy and professional interests should contribute to the development of more effective and efficient health

care industrial relations systems as well as more effective and efficient employers' organizations.

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APPENDICES

APPENDIX 1

SEMINARS AND MEETINGS

SEMINARS AND MEETINGS

1. January 24-25, 1974, Lethbridge, meeting, Alberta hospitals' personnel directors.

2. February 21, 1974, Vancouver, meeting with Hospital Employees Union (H.E.U.).

3. February 21, 1974, Vancouver, meeting with Registered Nurses Association of British Columbia (R.N.A.B.C.).

4. February 22, 1974, Vancouver, meeting with British Columbia Hospital Association (B.C.H.A.).

5. March 11-13, 1974, Ottawa, seminar sponsored by the University of Ottawa, Continuing Education Programme on Labour - Management Relations in Health Sciences.

6. March 14-15, 1974, Edmonton, meeting of Ontario, Manitoba, Saskatchewan, Alberta and British Columbia provincial health care labour relations organizations.

7. March 22, 1974, Edmonton, seminar, Alberta Hospital Association Trustees - Institute.

8. May 30, 1974, Edmonton, meeting of major hospitals.

9. October 9, 1976, Banff, seminar, Alberta Hospital Association Administrators Institute.

10. October 11, 1974, Calgary, meeting of major hospitals.

11. May 30-31, 1975, Vancouver, meeting of the British Columbia Hospital Association.

APPENDIX 2

EXCERPTS FROM A SURVEY OF ALBERTA HEALTH CARE INSTITUTIONS

ATTITUDE SURVEY

WORKING RELATIONSHIPS AND CONFLICT RESOLUTION ALTERNATIVES

ALBERTA HOSPITAL ASSOCIATION

B. Voigt

February 5, 1976

1. Do you think that some conflict between employer and employee is:

_____ inevitable and not to be considered bad

_____ inevitable and to be considered bad

_____ not inevitable and can be avoided completely

_____ not inevitable and usually can be avoided

COMMENTS:

2. How would you rate the overall relationship that your hospital has with its employees? Please circle the appropriate response.

1	2	3	4	5
no conflict at all in the relationship	less than average conflict in the relationship	a rather neutral relationship	more than average conflict in the relationship	great deal of conflict in the relationship

COMMENTS:

3. Using the same scale as above, how would you rate the specific relationship that your hospital has with the following groups of employees:

Nurses

1	2	3	4	5
no conflict at all in the relationship	less than average conflict in the relationship	a rather neutral relationship	more than average conflict in the relationship	great deal of conflict in the relationship

General Service Workers

1	2	3	4	5
no conflict at all in the relationship	less than average conflict in the relationship	a rather neutral relationship	more than average conflict in the relationship	great deal of conflict in the relationship

Technologists

1	2	3	4	5
no conflict at all in the relationship	less than average conflict in the relationship	a rather neutral relationship	more than average conflict in the relationship	great deal of conflict in the relationship

COMMENTS:

4. Do you feel hospital workers should have the right to strike?

Yes _____

No. _____

COMMENTS:

5. Would you ever take advantage in a dispute, as the employer, of locking out hospital workers?

Yes _____

No _____

COMMENTS:

6. To settle a dispute, would you agree to commit your hospital to final offer selection when either the union position would be adopted in total or the employers position would be adopted in total? (Final offer selection is defined in the Appendix.)

Yes _____

No _____

COMMENTS:

7. Would you agree to commit your hospital to final offer selection if clauses could be chosen from either the union position or employers position?

Yes _____

No _____

COMMENTS:

8. Do you think the government should "interfere" with the collective bargaining process by legislating workers back to work?

Yes _____

No _____

COMMENTS:

9. Do you agree in principle with the voluntary collective bargaining arbitration board provisions as specified in sections 135, 136 and 137 of the Alberta Labour Act which states that unsuccessul conciliation would be followed by binding arbitration? (Sections 135, 136 and 137 are provided in the Appendix for reference.)

Yes _____

No _____

COMMENTS:

10. Would you agree to commit your hospital to binding voluntary arbitration to settle disputes?

Yes _____

No _____

COMMENTS:

11. How would you characterize the relationship between the Alberta Hospital Association and the following unions?

A.A.R.N.

1	2	3	4	5
no conflict at all in the relation-ship	less than average conflict in the relation-ship	a rather neutral relation-ship	more than average conflict in the relation-ship	great deal of conflict in the relation-ship

C.U.P.E.

1	2	3	4	5
no conflict at all in the relation-ship	less than average conflict in the relation-ship	a rather neutral relation-ship	more than average conflict in the relation-ship	great deal of conflict in the relation-ship

11. Continued

C.S.A.A.

1	2	3	4	5
no conflict at all in the relation-ship	less than average conflict in the relation-ship	a rather neutral relation-ship	more than average conflict in the relation-ship	great deal of conflict in the relation-ship

H.S.A.A.

1	2	3	4	5
no conflict at all in the relation-ship	less than average conflict in the relation-ship	a rather neutral relation-ship	more than average conflict in the relation-ship	great deal of conflict in the relation-ship

COMMENTS:

12. What other comments, suggestions or feeling do you have concerning resolution of disputes in the health care industry?

COMMENTS:

FINAL OFFER SELECTION (EITHER - OR ARBITRATION)

If arbiration is to be used in the public sector, either on a compulsory or a voluntary basis, it is desirable to seek a form which maximizes the possibility of a negotiated agreement.

It is in that context that the proposal for "either-or" arbitration deserves serious consideration. Under that proposal, an arbitrator would not be free to compromise between the positions of the parties but would be required to accept one position or the other in toto. This might be done in one of two ways: either by presenting the arbitrator with the positions of the parties, on the basis of their prior negotiating record, without further hearing; or by holding a post-negotiation hearing before a tripartite arbitration board, during the course of which the parties might be allowed to modify their positions prior to final decision. Either way, the theory is that the process, instead of chilling bargaining, will induce the parties to develop their most "reasonable" positions prior to the arbitrator's decision. The idea has some antecendents in the procedures of British wage councils, and it has been advocated recently by the Nixon Administration as a means of resolving impasses in the transportation industry here.

APPENDIX

Division 10

Voluntary Collective Bargaining Arbitration Board

Agreement to apply to Minister

135. (1) The parties to a dispute may agree in writing

(a) to request the Minister to appoint a conciliation commissioner to effect a settlement of a dispute, and

(b) that if a conciliation commissioner fails to effect a settlement of the dispute, the matters in dispute will be referred to a collective bargaining arbitration board whose decision will be binding.

(2) Upon receipt of a request contained in an agreement made pursuant to subsection (1), the Minister shall appoint a conciliation commissioner.

(3) Where the conciliation commissioner is unable to effect a settlement of the dispute within 20 days of the date of his appointment or such longer period as may be agreed between the parties or fixed by the Minister, the conciliation commissioner shall report back to the Minister on the matters remaining in dispute between the parties. [1973, c. 33, s. 135]

Collective bargaining arbitration board

136. (1) Where the Minister receives a report pursuant to section 135, he shall serve notice on the parties to the dispute requiring each of them, within 10 days, to appoint a person to act as a member of a collective bargaining arbitration board.

(2) The two persons appointed to serve as members of the collective bargaining arbitration board shall, within five days of the appointment of the second person, appoint a third person to act as chairman.

(3) If no chairman is appointed, the Minister shall appoint a chairman on request of either party to the dispute.

(4) No person shall be appointed or shall act as a member of a collective bargaining arbitration board if the person is directly affected by the dispute or if the person has been involved in an attempt to negotiate or settle the dispute. [1973, c. 33, s. 136]

Powers of collective bargaining arbitration board

137. (1) Upon the appointment of the chairman of the collective bargaining arbitration board, the Minister shall designate the members as a collective bargaining arbitration board and send to the chairman a statement of the matters in dispute to be inquired into by them.

(2) The functions and procedural powers of the collective bargaining arbitration board shall be the same as those of a conciliation board.

(3) The collective bargaining arbitration board shall mediate between the parties and make all possible efforts to assist the parties to effect a settlement.

(4) If the collective bargaining arbitration board is unable to effect a settlement and in any event within 20 days after a statement of the dispute is sent to its chairman or such longer period as may be agreed between the parties or fixed by the Minister, the collective bargaining arbitration board shall make an award dealing with all matters in dispute.

(5) The award of a collective bargaining arbitration board is binding on the parties to the dispute and shall be included in the terms of a collective agreement.

(6) *The Arbitration Act* does not apply to arbitration under this section. [1973, c. 33, s. 137]

INSTITUTIONS SURVEYED

GENERAL HOSPITALS

Athabasca
Banff
Barrhead
Bashaw
Bassano
Beaverlodge
Bentley
Berwyn
Blairmore
Duclos, Bonnyville
St. Louis, Bonnyville
Bow Island
Boyle
Breton
Brooks
Calgary General
Grace, Calgary
Holy Cross, Rockyview, Calgary
Camrose
Canmore
Cardston
Carmangay
Castor
Cereal
Claresholm
Coaldale
Cold Lake
Consort
Coronation
Daysland
Devon
Didsbury
Drayton Valley
Drumheller
Eckville
Edmonton General
Miscericordia, Edmonton
Royal Alexandra, Edmonton
Edson
Elk Point
Elnora
Empress
Fairview
Fort Macleod
Fort McMurray
Fort Saskatchewan
Fort Vermilion
Galahad

GENERAL HOSPITALS

Glendon
Grande Cache
Grande Prairie
Hanna
Hardisty
High Level
High Prairie
High River
Hinton
Hythe
Innisfail
Islay
Jasper
Killam
Lac La Biche
Lacombe
Lamont
Leduc
Lethbridge
St. Michael's, Lethbridge
Magrath
Manning
Mannville
Mayerthorpe
McLennan
Medicine Hat
Milk River
Mundare
Myrnam
Olds
Oyen
Peace River
Picture Butte
Pincher Creek
Ponoka
Provost
Radway
Raymond
Red Deer
Redwater
Rimbey
Rocky Mountain House
St. Albert
St. Paul
Slave Lake
Smoky Lake
Spirit River
Stettler
Stony Plain
Sundre

GENERAL HOSPITALS

Taber
Three Hills
Tofield
Trochue
Turner Valley
Tow Hills
Valleyview
Vegreville
Vermilion
Viking
Vilna
Vulcan
Wainwright
Westlock
Wetaskiwin
Whitecourt
Willington

PROVINCIAL HOSPITAL (DEPARTMENT OF HEALTH)

Alberta Hospital Ponoka
Alberta Hospital Edmonton
Claresholm
Camrose, Rose Haven
Baker Memorial, Calgary
Deerhome, Red Deer
Alberta School, Red Deer
Raymond

FEDERAL HOSPITAL

Colonel Belcher, Calgary

Cardston, Blood Indian

Gleichen, Blackfoot Indian

Edmonton, Charles Camsell

PROVINCIAL HOSPITALS (VARIOUS HOSPITALS ACT)

Alberta Children's, Calgary

Foothills, Calgary

W. W. Cross, Edmonton

Glenrose, Edmonton

University of Alberta Hospital, Edmonton

AUXILIARY HOSPITALS

Calgary, Bethany

Cross Bow

Glenmore Park

Sarcee

Camrose, Bethany[1]

Claresholm Willow Creek

[1] These institutions did not receive questionnaires.

AUXILIARY HOSPITALS

Didsbury, Maountain View-Kneehill

Drumheller, J. Cramer

Edmonton, Allen Gray

Good Samaritan

Grandview

Lynnwood

Norwood

St. Joseph's

Aberhart

Grande Prairie

Killam, Flagstaff-Beaver

Lamont Smoky Lake

Lethbridge Rehabilitation

Lloydminster

Medicine Hat, Dr. Dan MacCharles

Peace River Fairview

Red Deer, Dr. Richard Parsons

Rimbey[1]

Settler, Dr. A. A. Kennedy

Vegreville, Minburn

Wainwright

Westlock, Barrhead-Thorhild

Wetaskiwin

Whitelaw

[1] These institutions did not receive questionnaires.

NURSING HOMES

Barrhead

Blairmore, Crowsnest

Brooks, Newell

Calgary, Beverly

- Blunt's Kenwood
- Bow Crest
- Bowview
- Brentwood
- Central Park Lodge
- Cedars
- Chinook
- Forest Grove
- Glamorgan
- Mayfair
- Parkland
- Scottish
- Southwood

Camrose, Bethany

Coronation

Didsbury, Mountain View-Kneehill

Drumheller, Dr. T. R. Ross Memorial

Edmonton, Central Park Lodge

- Good Samaritan
- Good Samaritan (Southgate)

NURSING HOMES

Edmonton, D.V.A.
Hardisty
Holyrood
Jasper Place Central Park
Jubilee Lodge
Parkland
Venta

Fairview

Fort Saskatchewan, Rivercrest

Grande Prairie, Central Park
Swan Haven

Hanna, Palliser

High Prairie, J. B. Wood

High River, Vulcan-Foothills

Lacombe

Lamont

Lethbridge, Edith Cavell
Southland

Lloydminster, Dr. Cooke

McLennan, Our Lady of the Lake

Medicine Hat, Riverview
Sunnyside

Midnapore, Father Lacombe

Peace River, Sutherland

Ponoka, Northcott

NURSING HOMES

Provost

Red Deer, Valley Park Manor

St. Albert, Youville

Sherwood Park

Smoky Lake

Stettler

Stony Plain, Good Samaritan

Linden

Two Hills

Vermilion, Alice Keith

Westlock

Wetaskiwin

Table 17. RESPONSE BY TYPE OF INSTITUTION

Type of Institution	Number of Institutions (Administrations) In Province	Number of Institutions (Administrations) Surveyed	Number of Responses (% of Administrations) Surveyed
General Hospital (active treatment)	121 (120)	121 (120)	79 (66%)
Auxiliary Hospitals	30 (25)	27 (22)	13 (59%)
Nursing Homes	76 (76)	61 (61)	19 (33%)
Provincial Hospitals	8 (8)	8 (8)	5 (63%)
Federal Hospital	4 (4)	4 (4)	1 (25%)
Total	239 (233)	221 (215)	117 (54%)

Table 18 RESPONSES BY TYPE OF INSTITUTION - PROVINCIAL HOSPITALS

PROVINCIAL HOSPITAL
8 institutions
QUESTION (5 respondents)

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	5		1	0		1	0		0		0		Y	1		1		2	
2	0		2	2		2	2		2		2		N	3		3		1	
3	0		3	1		3	0		1		2		na	1		1		2	
4	0		4	2		4	2		2		0			5		5		5	
na	0		5	0		5	0		0		0								
	5		na	0		na	1		0		1								
			5				5		5		5								

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
3		4		4		3		1	2		1		1		1	
0		0		0		0		2	0		0		1		0	
2		1		1		2		3	2		0		3		1	
5		5		5		5		4	0		3		0		1	
								5	0		0		0		0	
								na	1		1		0		2	
									5		5		5		5	

Table 19 RESPONSES BY TYPE OF INSTITUTION - FEDERAL HOSPITALS

FEDERAL HOSPITAL
4 institutions

QUESTION (1 respondent)

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	1		1	0		1	0		0		0		Y	1		0		1	
2	0		2	1		2	1		1		1		N	0		1		0	
3	0		3	0		3	0		0		0		na	0		0		0	
4	0		4	0		4	0		0		0			1		1		1	
na	0		5	0		5	0		0		0								
	1		na	0		na	0		0		0								
				1			1		1		1								

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
0		1		1		1		1	0		0		0		0	
0		1		0		0		2	0		0		0		0	
0		0		0		0		3	0		0		0		0	
1		1		1		1		4	0		0		0		0	
								5	0		0		0		0	
								na	1		1		1		1	
									1		1		1		1	

Table 20 RESPONSES BY TYPE OF INSTITUTION - AUXILIARIES

AUXILIARIES
30 institutions, 25 administrations, 22 surveyed administrations
QUESTION (13 respondents) 10 with unions, 3 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	11	85	1	1	8	1	4	31	1	8	3	23	Y	4	31	7	54	5	38
2	0		2	10	77	2	6	46	6	46	3	23	N	9	69	6	46	7	54
3	0		3	2	15	3	3	23	2	15	2	15	na	0		0		1	8
4	2	15	4	0		4	0		3	23	1	8		13	100	13	100	13	100
na	0		5	0		5	0		0		0								
	13	100	na	0		na	0		1	8	4	31							
				13	100		13	100	13	100	13	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
8	62	11	85	12	92	9	69	1	2	15	0		0		2	15
4	31	1	8	0		2	15	2	6	46	3	23	2	15	2	15
1	8	1	8	1	8	2	15	3	3	23	2	15	1	8	3	23
13	101	13	101	13	100	13	99	4	0		4	31	4	31	1	8
								5	0		1	8	1	8	0	
								na	2	15	3	23	5	38	5	38
									13	99	13	100	13	100	13	99

Table 21 RESPONSES BY TYPE OF INSTITUTION - NURSING HOMES

NURSING HOMES
76 institutions, 61 institutions surveyed
QUESTION (19 respondents) 3 with unions, 16 without unions

1		2		3	N	G	T	4		5	6
R	# %	R	# %	R	# %	# %	# %	R	# %	# %	# %
1	10	1	5	1	6	3	3	Y	3	8	9
2	1	2	12	2	12	13	8	N	14	9	6
3	3	3	2	3	0	2	0	na	2	3	4
4	5	4	0	4	0	0	0		19	19	19
na	0	5	0	5	0	0	0				
	19	na	0	na	0	1	8				
			19		19	19	19				

7	8	9	10	11	AA	CP	CS	HS
# %	# %	# %	# %	R	# %	# %	# %	# %
13	18	16	14	1	3	1	2	3
2	0	1	2	2	5	4	1	2
4	1	2	3	3	7	4	2	3
19	19	19	19	4	1	4	3	2
				5	0	3	2	1
				na	3	3	10	8
					19	19	19	19

Table 22 RESPONSES BY TYPE OF INSTITUTION - ALL GENERAL/MUNCIPAL HOSPITALS

ALL GENERAL/MUNICIPAL HOSPITAL
121 institutions, 120 administrations, 16 without unions

QUESTION (79 respondents) 9 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	62	78	1	1	1	1	4	5	7	9	16	20	Y	18	23	26	33	38	48
2	1	1	2	65	83	2	57	72	51	65	50	63	N	60	76	51	65	33	42
3	1	1	3	12	15	3	14	18	14	18	11	14	na	1	1	2	3	8	10
4	15	19	4	1	1	4	4	5	7	9	2	3		79	100	79	100	79	100
na	0		5	0		5	0		0		0								
	79	99	na	0		na	0		0		0								
				79	100		79	100	79	101	79	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
54	68	65	82	71	90	67	85	1	3	4	1	1	2	3	6	8
16	20	8	10	6	8	6	6	2	41	42	7	9	13	17	30	38
9	11	6	8	2	3	7	9	3	23	29	8	10	10	13	26	33
79	99	79	100	79	101	79	100	4	3	4	41	52	28	38	5	6
								5	0		14	18	4	5	0	
								na	9	11	8	10	22	28	12	15
									79	100	79	100	79	101	79	100

Table 23 RESPONSES BY SIZE OF INSTITUTION - 1 TO 14 BEDS

1 - 14 BEDS
7 institutions, 3 without unions

QUESTION (4 respondents) 2 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	3	75	1	0		1	0		0		0		Y	0		0		2	50
2	0		2	2	50	2	3	75	2	50	3	75	N	4	100	4	100	1	25
3	0		3	2	50	3	1	25	2	50	1	25	na	0		0		1	25
4	1	25	4	0		4	0		0		0			4	100	4	100	4	100
na	0		5	0		5	0		0		0								
4		100	na	0		na	0		0		0								
				4	100		4	100	4	100	4	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
1	25	2	50	3	75	3	75	1	0		0		0		0	
1	25	0		0		0		2	1	25	0		0		1	25
2	50	2	50	1	25	1	25	3	1	25	0		1	25	0	
4	100	4	100	4	100	4	100	4	0		1	25	1	25	0	
								5	0		1	25	0		0	
								na	2	50	2	50	2	50	3	75
									4	100	4	100	4	100	4	100

Table 24 RESPONSES BY SIZE OF INSTITUTION - 15 TO 24 BEDS

15 - 24 BEDS
16 institutions, 5 without unions
QUESTION (8 respondents) 2 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	5	63	1	0		1	1	13	0		0		Y	0		1	13	5	63
2	0		2	8	100	2	7	88	8	100	8	100	N	8	100	6	75	3	38
3	0		3	0		3	0		0		0		na	0		1	13	0	
4	3	38	4	0		4	0		0		0			8	100	8	101	8	101
na	0		5	0		5	0		0		0								
	8	101	na	0		na	0		0		0								
				8	100		8	101	8	100	8	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
6	75	8	100	7	88	8	100	1	0		0		0		0	
2	25	0		1	13	0		2	5	63	1	13	1	13	3	38
0		0		0		0		3	1	13	2	25	2	25	5	63
8	100	0	100	8	101	8	100	4	1	13	2	25	3	38	0	
								5	0		3	38	0		0	
								na	1	13	0		2	25	0	
									8	102	8	101	8	101	8	101

Table 25 RESPONSES BY SIZE OF INSTITUTION - 25 TO 30 BEDS

25 - 30 BEDS
12 institutions, 4 without unions
QUESTION (14 respondents), 2 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	11	79	1	0		1	0		0		4	29	Y	5	36	6	43	6	64
2	0		2	9	64	2	9	64	11	79	7	50	N	9	64	8	57	4	29
3	1	7	3	4	29	3	3	21	2	14	2	14	na	0		0		1	7
4	2	14	4	1	7	4	2	14	1	7	1	7		14	100	14	100	14	100
na	0		5	0		5	0		0		0								
	14	100	na	0		na	0		0		0								
				14	100		14	99	14	100	14	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
12	86	11	79	11	79	12	86	1	0		0		0		0	
2	14	2	14	3	21	2	14	2	6	43	1	7	3	21	4	29
0		1	7	0		0		3	7	50	0		2	14	6	43
14	100	14	100	14	100	14	100	4	0		9	64	5	36	1	7
								5	0		3	21	1	7	0	
								na	1	7	1	7	3	21	3	21
									14	100	14	99	14	99	14	100

Table 26 RESPONSES BY SIZE OF INSTITUTION - 31 TO 34 BEDS

31 - 34 BEDS
14 institutions, 2 without unions

QUESTION (12 respondents) 2 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	9	75	1	0		1	0		2	17	4	33	Y	4	33	2	17	7	58
2	0		2	11	92	2	8	67	8	67	6	50	N	8	67	10	83	3	25
3	0		3	1	8	3	4	33	2	17	2	17	na	0		0		2	17
4	3	25	4	0		4	0		0		0			12	100	12	100	12	100
na	0		5	0		5	0		0		0								
	12	100	na	0		na	0		0		0								
				12	100		12	100	12	101	12	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
8	67	10	83	10	83	9	75	1	0		0		0		0	
1	8	2	17	1	8	0		2	5	42	1	8	3	25	4	33
3	25	0		1	8	3	25	3	5	42	1	8	1	8	5	42
12	99	12	100	12	99	12	100	4	0		6	50	2	17	0	
								5	1		2	17	1	8	0	
								na	2	17	2	17	5	42	3	25
									12	101	12	100	12	100	12	100

Table 27 RESPONSES BY SIZE OF INSTITUTION - 35 TO 49 BEDS

35 - 49 BEDS
16 institutions, 2 without unions

QUESTION (12 respondents) 1 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	11	92	1	1	8	1	2	17	2	17	4	33	Y	2	17	3	25	4	33
2	0		2	9	75	2	8	67	7	58	8	67	N	10	83	9	75	7	58
3	0		3	2	17	3	2	17	2	17	0		na	0		0		1	8
4	1	8	4	0		4	0		1	8	0			1s	100	12	100	12	99
na	0		5	0		5	0		0		0								
	12	100	na	0		na	0		0		0								
				12	100		12	101	12	100	12	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
9	75	11	92	12	100	11	92	1	1	8	0		0		0	8
2	17	0		0		0		2	8	67	2	17	3	25	5	42
1	8	1	8	0		1	8	3	2	17	2	17	3	25	4	33
12	100	12	100	12	100	12	100	4	0		5	42	2	17	1	8
								5	0		2	17	2	17	0	
								na	1	8	1	8	2	17	1	8
									12	100	12	101	12	101	12	99

Table 28 RESPONSES BY SIZE OF INSTITUTION - 50 TO 59 BEDS

50 - 59 BEDS
14 institutions

QUESTION (10 respondents)

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	7	70	1	0		1	0		0		1	10	Y	2	20	6	60	3	30
2	1	10	2	9	90	2	8	80	7	70	6	60	N	8	80	4	40	6	60
3	0		3	1	10	3	1	10	2	20	2	20	na	0		0		1	10
4	2	20	4	0		4	1	10	1	10	1	10		10	100	10	100	10	100
na	0		5	0		5	0		0		0								
	10	100	na	0		na	0		0		0								
				10	100		10	100	10	100	10	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
9	90	7	70	10	100	10	100	1	0		0		1	10	2	20
0		3	30	0		0		2	5	50	1	10	2	20	4	40
1	10	0		0		0		3	4	40	2	20	1	10	2	20
10	100	10	100	10	100	10	100	4	1	10	6	60	5	50	2	20
								5	0		1	10	0		0	
								na	0		0		1	10	0	
									10	100	10	100	10	100	10	100

Table 29 RESPONSES BY SIZE OF INSTITUTION - 60 TO 99 BEDS

60 - 99 BEDS
13 institutions

QUESTION (7 respondents)

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	4		1	0		1	0		3	43	2	29	Y	1	14	1	14	3	43
2	0		2	6	86	2	4	57	3	43	3	43	N	5	71	6	86	4	57
3	0		3	1	14	3	2	29	1	14	2	29	na	1	14	0		0	
4	3	43	4	0		4	1	14	0		0			7	99	7	100	7	100
na	0		5	0		5	0		0		0								
	7	100	na	0		na	0		0		0								
				7	100		7	100	7	100	7	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
7	100	6	86	7	100	6	86	1	1	14	1	14	1	14	1	14
0		0		0		0		2	3	43	0		0		3	43
0		1	14	0		1	14	3	1	14	0		0		1	14
7	100	7	100	7	100	7	100	4	1	14	5	71	4	57	1	14
								5	0		0		0		0	
								na	1	14	1	14	2	29	1	14
									7	99	7	99	7	100	7	99

Table 30 RESPONSES BY SIZE OF INSTITUTION - 100 TO 399 BEDS

100 - 399 BEDS
11 institutions

QUESTION (8 respondents)

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	8	100	1	0		1	1	13	0		0		Y	3	38	4	50	4	50
2	0		2	7	88	2	6	75	4	50	6	75	N	5	63	3	38	2	25
3	0		3	1	13	3	1	13	2	25	2	25	na	0		1	13	2	25
4	0		4	0		4	0		2	25	0			8	101	8	101	8	100
na	0		5	0		5	0		0		0								
	8	100	na	0		na	0		0		0								
				8	101		8	101	8	100	8	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
2	25	7	88	7	88	6	75	1	1	13	0		0		1	13
4	50	0		1	13	2	25	2	5	63	1	13	0		3	38
2	25	1	13	0		0		3	1	13	1	13	0		3	38
8	100	8	101	8	101	8	100	4	0		4	50	5	63	0	
								5	0		1	13	0		0	
								na	1	13	1	13	3	38	1	13
									8	102	8	102	8	101	8	102

Table 30 RESPONSES BY SIZE OF INSTITUTION - OVER 400 BEDS

OVER 400 BEDS

9 institution; 8 administrations all with unions

QUESTION (4 respondents)

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	4	100	1	0		1	0		0		1	25	Y	1	25	3	75	2	50
2	0		2	4	100	2	4	100	1	25	3	75	N	1	75	1	25	2	50
3	0		3	0		3	0		1	25	0		na	0		0		0	
4	0		4	0		4	0		2	50	0			4	100	4	100	4	100
na	0		5	0		5	0		0		0								
	4	100	na	0		na	0		0		0								
				4	100		4	100	4	100	4	100							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
0		3	75	4	100	2	50	1	0		0		0		1	25
4	100	1	25	0		1	25	2	3	75	0		1	25	3	75
0		0		0		1	25	3	1	25	0		0		0	
4	100	4	100	4	100	4	100	4	0		3	75	1	25	0	
								5	0		1	25	0		0	
								na	0		0		2	50	0	
									4	100	4	100	4	100	4	100

Table 32 RESPONSES BY ALL INSTITUTIONS

ALL INSTITUTIONS
239 institutions

QUESTION (117 respondents) 28 without unions

1			2			3	N		G		T		4			5		6	
R	#	%	R	#	%	R	#	%	#	%	#	%	R	#	%	#	%	#	%
1	89	76	1	7	6	1	15	13	11	9	22	19	Y	27	23	42	36	55	47
2	2	2	2	90	77	2	78	67	73	62	64	55	N	86	74	69	59	47	40
3	4	3	3	17	15	3	17	15	19	16	15	13	na	4	3	6	5	15	13
4	22	19	4	3	3	4	6	5	12	10	3	3		117	100	117	100	117	100
na	0		5	0		5	0		0		0								
	117	100	na	0		na	1	1	2	2	13	11							
				117	101		117	101	117	99	117	101							

7		8		9		10		11	AA		CP		CS		HS	
#	%	#	%	#	%	#	%	R	#	%	#	%	#	%	#	%
79	68	98	84	104	89	94	80	1	10	9	3	3	5	4	12	10
22	19	19	9	7	6	9	8	2	52	44	14	12	17	15	34	29
16	14	9	8	6	5	14	12	3	35	30	14	12	15	13	33	28
117	100	117	100	117	100	117	100	4	4	3	52	44	35	30	9	8
								5	0		18	15	7	6	1	1
								na	16	14	16	14	38	32	28	24
									117	100	117	100	117	100	117	100

APPENDIX 3

COLLECTIVE BARGAINING IN ONTARIO HOSPITALS MAY 1976

HOSPITAL
PERSONNEL
RELATIONS
BUREAU

Suite 1100, 55 Queen St. E.
Tel: (416) 868-1730

Mailing Address: P.O. Box 7004
Adelaide St. P.O.
TORONTO, Ontario M5C 2K7

RECEIVED
MAY 25 1976

May 14, 1976

Ms. Barbara C. Voigt
Alberta Systems Development Group
Sixth Floor
10025-108 Street
EDMONTON, Alberta
T5J 1K9

Dear Ms. Voigt:

Collective Bargaining in Ontario Hospitals.

One could probably write a book about the collective bargaining processes of Ontario hospitals, using as one's text the recommendations of the Report of the Hospital Inquiry Commission, but I will refrain from such detail in replying to your letter of April 28th because I fear that much of it would be too complex a picture as seen from Alberta.

This letter will therefore be restricted to the summary of recommendations given on pages 9 and 10 of the Johnston Report, and I will follow the paragraph headings which are underlined on those pages.

Criteria

Although the Commission recommended that criteria should be set up, and embodied in the legislation, to assist arbitrators in arriving at settlements, nothing has yet been done to this end. This is because we have not yet proceeded very far with the proposed job evaluation system which was recommended in paragraph 4 under this heading. However, a Job Evaluation Steering Committee has been set up by the Ministry of Labour under the chairmanship of Mr. A. S. Tirrell, who was one of the Commissioners who subscribed to the Report. The work of this committee has been slow in getting underway, partly because of the need to convince both management and unions of the need to proceed with a job evaluation project, and partly because of lack of funds. The first obstacle was partially overcome by a very successful three day seminar held at the beginning of February. Management

2/. . .

and union representatives attended this in equal numbers, and as prejudices were overcome, so the prospect of a job evaluation programme for the industry became more acceptable. Unfortunately the cost of the programme and the availability of staff to assist in its implementation remain serious problems, though Mr. Tirrell's committee is working on these matters and he himself is pressing onward with the project. The concern of management is the overall long term cost of the implementation of any system that is developed, especially in these days of financial stringency in the health care delivery system. Moreover, government is reluctant to underwrite the cost of implementing a system, and without such an undertaking the hospitals whose budgets are now being severely restricted are less than enthusiastic about the implications for them of such a development. Like many other problems in life, this may all prove to be far less troublesome in reality than it appears to be in the abstract, and we will have to await the outcome of events. It must be recognized however that the provision of criteria of this kind is essential if there is to be a forward development of labour relations practices and procedures in the hospital industry in Ontario, and much of the remainder of the proposals in the Report hangs upon the implementation of this first recommendation.

Structure of Bargaining

The structure now in effect for group bargaining in the industry is a central system which, on the management side, reflects the type of organisational plan which is shown on page 38 of the Report. There is not an "accredited employers' bargaining agency" however, nor have there been any moves towards a joint council of trade unions. Thus the hospitals which have bargaining units with a particular union find themselves grouped together for negotiations with that union, but without any formalised relationship (other than the close liaison which one might expect) to the negotiations that take place with other unions. Naturally, of course, any negotiations conducted for a particular section of the employee spectrum take into account the differentials which exist between that and other groupings, and thus we tend to perpetuate the present job relationships which existed before the Johnston Commission was set up. Until a job evaluation system has been developed, it will be difficult to break these relationships or to change them at all in any significant way, for each group of employees jealously guards the relationship which it has with other groups. Thus for example the Registered Nursing Assistant traditionally occupies a position some 70% below the wages enjoyed by registered nurses, and the same type of pattern (with different percentages) applies elsewhere.

3/. . .

As you can imagine, the engineering unions did not take kindly to the recommendation that their craft units should be eliminated from the structure of bargaining, and therefore they are still very much in existence, and currently the Canadian Union of Operating Engineers is jointly negotiating with a group of hospitals.

This type of half-way house in bargaining structures is, so far as the nurses are concerned (the Ontario Nurses' Association is the union concern) conducted on a province-wide basis. To all intents and purposes the service workers negotiations with CUPE and SEIU are also on a province-wide basis, though there is no movement towards a "master contract" as yet. This is an objective which the ONA would like to achieve, and there is more credibility about that for them than there is for the service workers. It is thought by some that collective agreements for the latter should, in monetary terms, reflect the wage rates which are paid in the different regions. The acceptance of provincial wage rates would be a difficult pill for hospitals to swallow in so far as they would then, in the remoter areas, become the trend setters. Reaction from local industries and other employers would obviously be adverse to this.

The lack of an accredited bargaining agency for hospitals and a council of trade unions has another effect, namely that uniform interpretation of collective agreements is still an objective to be achieved in the future. While the simplistic approach of Johnston to this matter sounds appealing, there are obvious problems where individual hospitals treasure their own autonomy, and do not take kindly to the thought of having every detail of their collective agreements centrally administered as well as centrally negotiated. This would leave them with little individuality of their own. This may be a reactionary approach, but it is a natural one and a considerable educative process would be involved in any movement toward central administration. It needs to be seen in perspective, because central bargaining is concentrated on central issues (predominantly, but not exclusively monetary) and local issues are still bargained locally at the individual hospitals, thus preserving their autonomy in matters which reflect their own individuality. Notwithstanding this the pressure of arbitration awards relating to very similar contracts does tend to force upon hospitals a similar interpretation of contractual language and the trend can thus be seen to have already set in towards centralized administration and interpretation.

One final point a propos of the representation of government at the bargaining table. In Ontario, this is not the case and while the Ministry of Health, as paymaster, is kept

4/. . .

well informed of the bargaining process, neither the government nor hospitals wish to have a representative of the Ministry at the bargaining table, for this would tend to reduce the position of hospitals to that of mere ciphers, and the bargaining would then seem to be taking place directly between unions and the government. This would not reflect the system of management of hospitals by local boards of trustees which is the practice in Ontario. Indeed it would go a long way to upsetting that arrangement, and would be a very disturbing influence.

Resource Centre

Regrettably, no resource centre has been set up. The desirability of an independent well of pure water from which both unions and management can draw and then distill the statistics which they need is recognized, but still has not been achieved. Thus once more the process of developing labour relations in the industry is being handicapped for the lack of movement in regard to essential matters. Earlier I referred to the same problem in regard to Job Evaluation, and here too the absence of a resource centre is a severe handicap. Arbitrators need this type of information just as much as negotiators, and it is regrettable that it has not yet been brought about. This is probably due to a desire on government's part to widen the scope of such a resource centre from that of the public health industry to all areas of public employment, inclusive of education (to name a very obvious candidate) and the rest of the quasi governmental field. Thus the process of getting a resource centre underway has been held up, and now with the financial problems which all provinces are confronted with, it begins to appear doubtful whether Ontario will be able to develop what Johnston recommended. This leaves us in the hands of Statistics Canada, and they are now apparently developing their data on wages and related statistics on a provincial basis, so we may ultimately have to turn to Ottawa for the information that we require. This in its own way raises other interesting problems.

Changes in Arbitration Process

Notwithstanding the recommendations of the Commission, no changes in arbitration procedures have yet been brought about. At the same time it should be recognized that with the movement towards centralized bargaining, the number of interest disputes which occur are very much reduced, and thus it is possible to find suitable arbitrators, and to get decisions, much quicker than was the case when individual

5/. . .

hospitals each went their own way to arbitration, and arbitrators were fully booked up for long periods at a time. It must also be remembered that the creation of the Anti-Inflation Board has also had an effect upon the arbitration process.

This is a very brief summary of the main issues covered by the recommendations in the Johnston Commission's Report, and they touch on some of the questions that you raised in your letter. I think that you might well have further questions, and if you care to phone me some time about these, giving me advance notice of the kind of problem that still exists, I would be happy to elaborate on what I have said above.

I hope this helps.

Yours sincerely,

John S. Sheriff,
Executive Director

JSS:jt

APPENDIX 4

ALTERNATIVE ORGANIZATIONAL STRUCTURES
IDENTIFIED BY THE A.H.A.
FOR THE HEALTH CARE COLLECTIVE BARGAINING

ALTERNATIVE ORGANIZATIONAL STRUCTURES

Several alternative organizational structures were identified by the Task Force for designing a more effective and efficient A.H.A. labour relations service. These alternative organizational structures listed below range from each hospital acting individually with each union to a single representative administrative group acting provincially with a single representative labour group.

1. INDIVIDUAL BARGAINING

All hospitals negotiate individually with each union with central coordination and research.

A central coordinating and research body might provide guidelines to hospital administrators on any number of topics relating to labour relations. The structure and role of such a group would require further definition.

2. REGIONAL BARGAINING

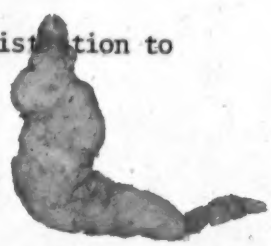
(a) A regional bargaining unit representing the hospitals' administrations negotiate, with central coordination and research, with.

(i) all union bargaining units at the same time,
(ii) each union individually, or
(iii) bargain hospital by hospital with each union.

In the above three alternatives, the common element would be a representative group of hospital administrators which would draw upon a central coordinating and research body for guidelines. This administrative group could then bargain with unions in any of three ways:

(i) with all unions present at the same time,
(ii) with each union individually, or
(iii) hospital by hospital such that the regional administrative group would visit each hospital and there bargain with the union(s) involved.

(b) A single central group representing administration to bargain on a regional basis with;



(i) all unions at the same time,
(ii) each union individually, or
(iii) bargain hospital by hospital with each union.

These three alternatives have as the common element a single central group to negotiate on behalf of hospital administrations labour contracts. This group would bargain on a regional basis, perhaps travelling to each region, with

(i) all unions at the same time,
(ii) each union individually, or
(iii) hospital by hospital such that the central group might negotiate a common regional contract, or only those regional or local issues extra to a province wide contract.

3. PROVINCE WIDE BARGAINING

(a) A single central group would go out to each hospital and bargain on behalf of administration with:

(i) all unions at the same time, or
(ii) each union individually.

This central administrative group would negotiate for the hospital the entire contract including any local issue.

(b) A single central group would bargain on behalf of all hospital administrations with:

(i) all unions at the same time, or
(ii) each union individually.

Local issues might be left up to the individual hospital with central coordination and research.

APPENDIX 5

ORGANIZATIONAL STRUCTURE OF THE ALBERTA HEALTH CARE INDUSTRY LABOUR RELATIONS FROM SPRING 1970 TO FALL 1975

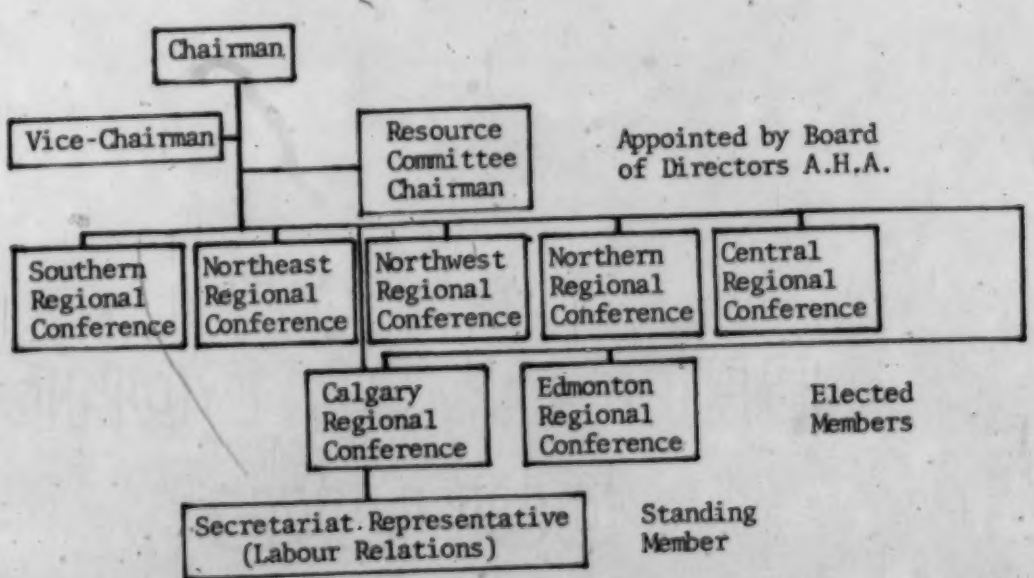
ORGANIZATIONAL STRUCTURE OF ALBERTA HEALTH CARE INDUSTRY LABOUR RELATIONS FROM SPRING 1970 TO SUMMER 1974

E.R.C.

The Employment Relations Committee (E.R.C.) was formed during the Spring of 1970 to provide policies and guidelines for the labour relations function of the Alberta Hospital Association (A.H.A.).

The structure of the E.R.C. is diagrammed below. The Chairman, Vice-Chairman, and Resource Committee Chairman were A.H.A. Board of Directors' appointments. One member was elected from each of the eight A.H.A. regions, and one standing member represented the labour relations function of the A.H.A. Secretariat. All members of the E.R.C. except the Secretariat representative were Trustees.

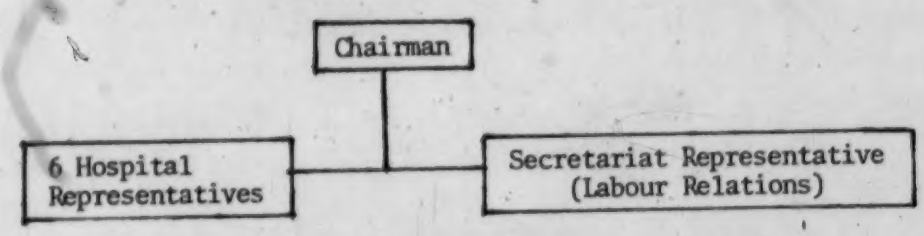
Diagram 22 E.R.C. STRUCTURE (1970)



RESOURCE COMMITTEE

The E.R.C. Resource Committee was formed to provide research services for the negotiating teams. The structure of the Resource Committee is diagrammed below. The Chairman and all six hospital representatives were appointed by the E.R.C. An additional standing member represented the labour relations functions of the Secretariat.

Diagram 23 E.R.C. RESOURCE COMMITTEE (1970)



All positions appointed by E.R.C.

LINES OF COMMUNICATION (1970)

Regional Representation

As indicated in Diagram 6, communication with hospitals was effected via regional representation on the E.R.C. The representatives, trustees only, did not participate in at-the-table negotiations, generally did not have experience in labour relations, yet they provided bargaining guidelines for the negotiating teams.

Resource Committee

The purpose of the Resource Committee was to provide data for use by negotiating teams during bargaining. The Resource Committee did not however communicate directly with negotiating teams.

Negotiating Teams

Negotiating teams operated independently of each other. There is no formal communication back to hospitals on the progress of negotiations.

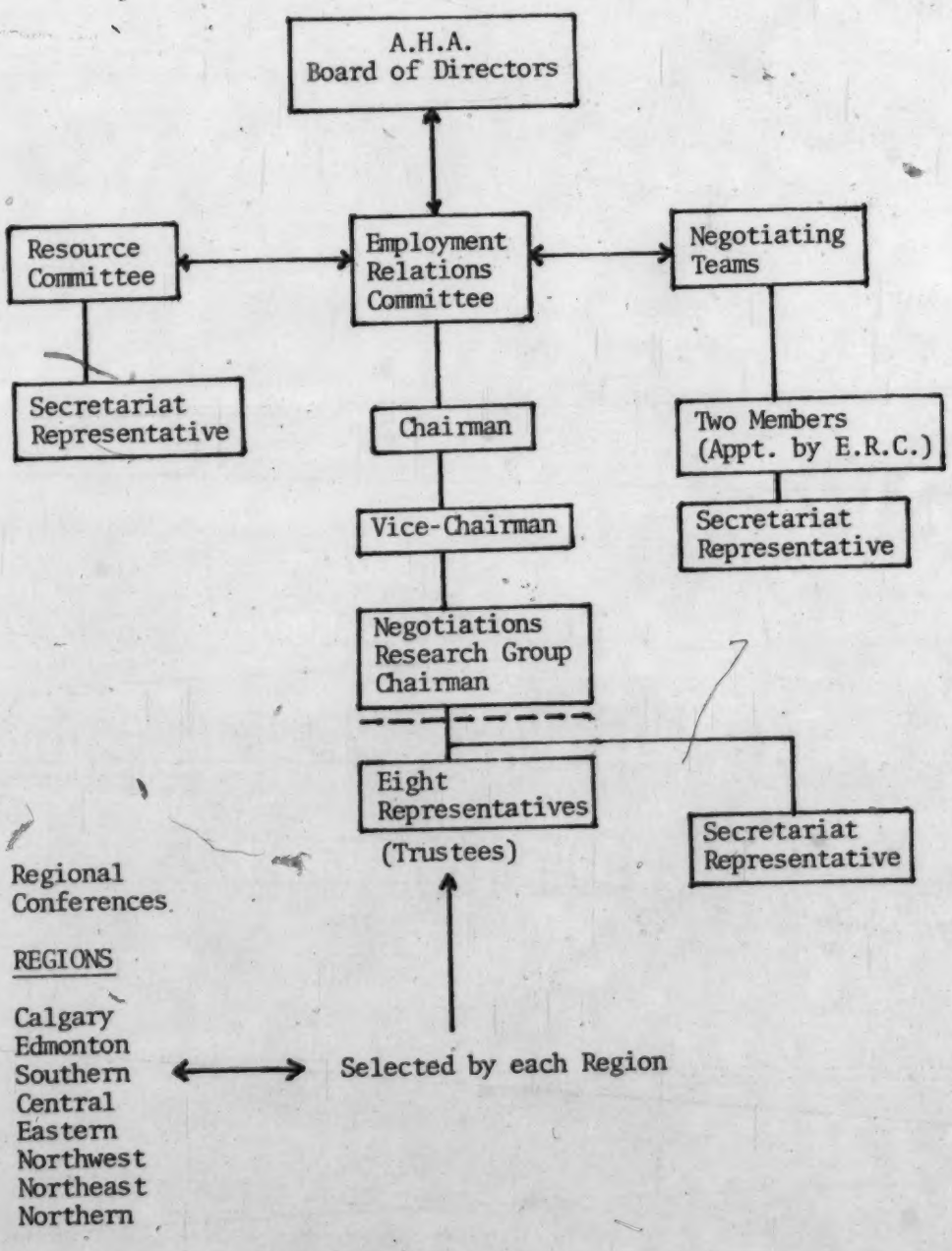
E.R.C.

Communication among the employement relations services was channelled through the E.R.C.

Secretariat Representation

The single constant in this structure, and the vehicle for communication was the secretariat representative.

Diagram 24 EMPLOYMENT RELATIONS SERVICES LINES OF COMMUNICATION (1970)



NEGOTIATING TEAMS

Four negotiating teams provided the collective bargaining service for the A.H.A. Each team was composed of representatives from hospitals and one member of the labour relations service of the A.H.A. Secretariat. Negotiating teams operated independently of each other.

The four negotiating teams were divided according to unions confronted i.e.,

1. Alberta Association of Registered Nurses (A.A.R.N.) and Alberta Certified Nursing Association (A.C.N.A.A.)
2. Canadian Union of Public Employees (C.U.P.E.) and Service Employees International Union (S.E.I.U.)
3. Health Sciences Association of Alberta (H.S.A.A.) and
4. Canadian Society of Hospital Pharmacists (C.S.H.P.), Alberta Registered Dietitians Association (A.R.D.A.), Association of Chartered Physiotherapists of Alberta (A.C.P.A.) and, Alberta Society of Occupational Therapists (A.S.O.T.).

The Secretariat negotiated with the Civil Service Association (C.S.A.) on behalf of the Provincial General Hospitals. The Secretariat also negotiated on behalf of six hospitals the International Union of Operating Engineers (I.U.O.E.) contract.

The organizations of union negotiations prior to 1974 are diagrammed in the following pages.

Diagram 25 COLLECTIVE BARGAINING STRUCTURES - A.A.R.N.

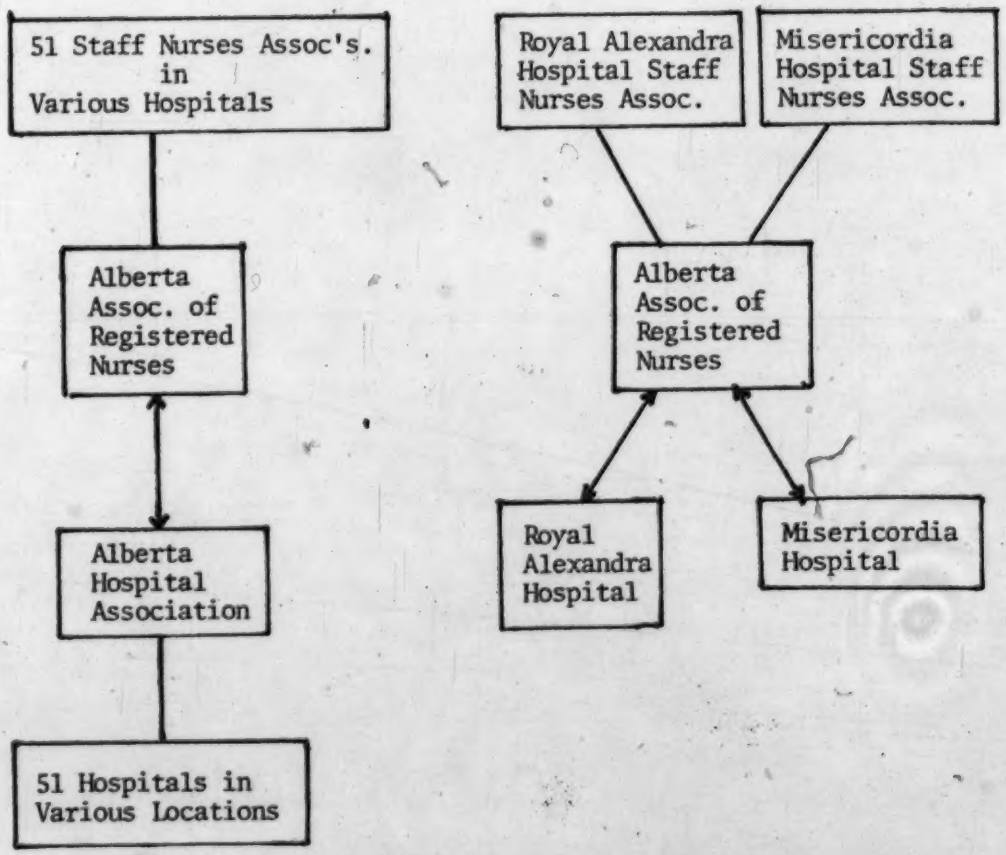

51 Staff Nurses Assoc's. in Various Hospitals
Alberta Assoc. of Registered Nurses
Alberta Hospital Association
51 Hospitals in Various Locations
Royal Alexandra Hospital Staff Nurses Assoc.
Misericordia Hospital Staff Nurses Assoc.
Alberta Assoc. of Registered Nurses
Royal Alexandra Hospital
Misericordia Hospital

Diagram 26 COLLECTIVE BARGAINING STRUCTURES - C.U.P.E.

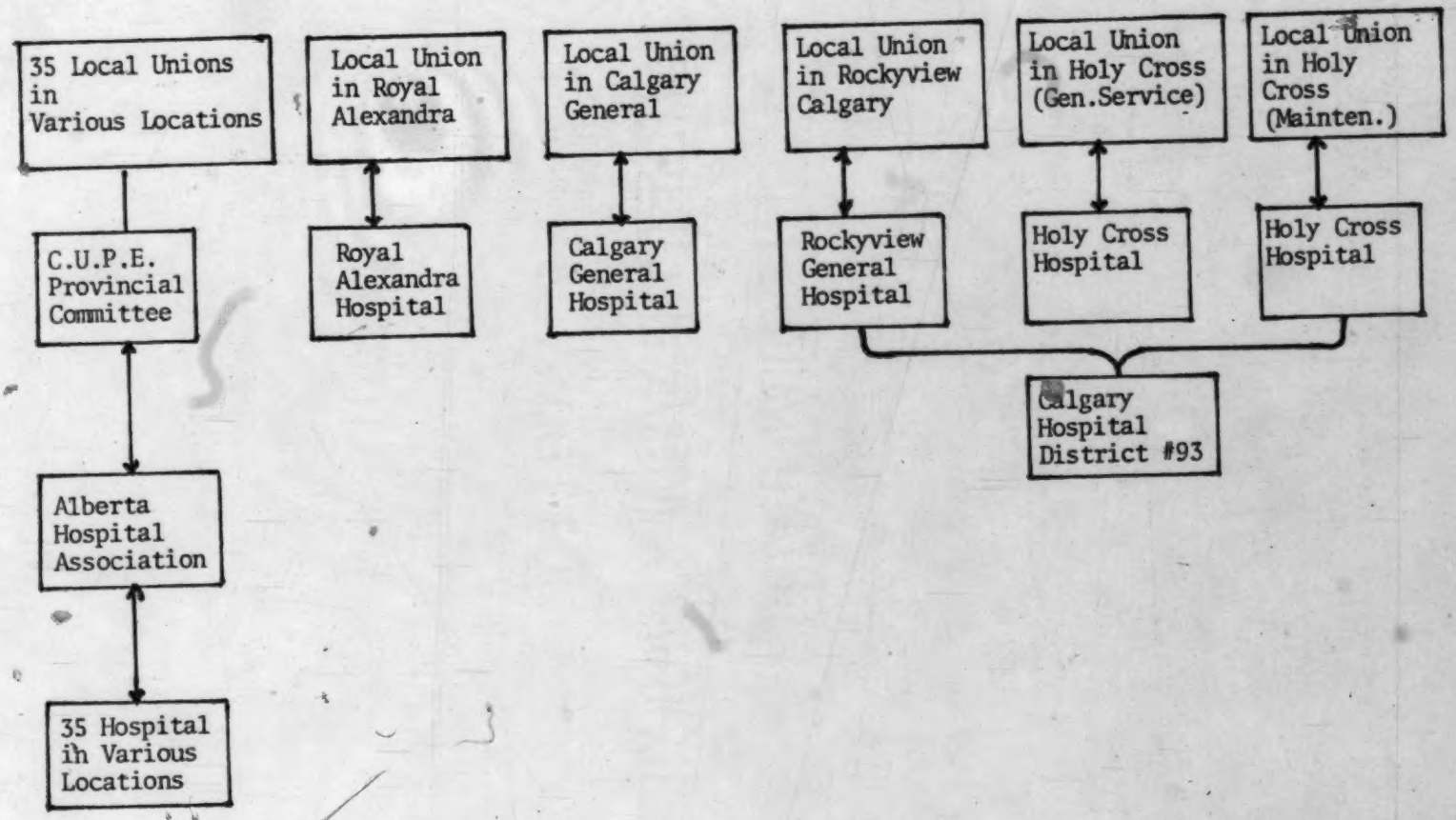

35 Local Unions in Various Locations
Local Union in Royal Alexandra
Local Union in Calgary General
Local Union in Rockyview Calgary
Local Union in Holy Cross (Gen.Service)
Local Union in Holy Cross (Mainten.)
C.U.P.E. Provincial Committee
Royal Alexandra Hospital
Calgary General Hospital
Rockyview General Hospital
Holy Cross Hospital
Holy Cross Hospital
Calgary Hospital District #93
Alberta Hospital Association
35 Hospital in Various Locations

Diagram 27 COLLECTIVE BARGAINING STRUCTURES - S.E.I.U.

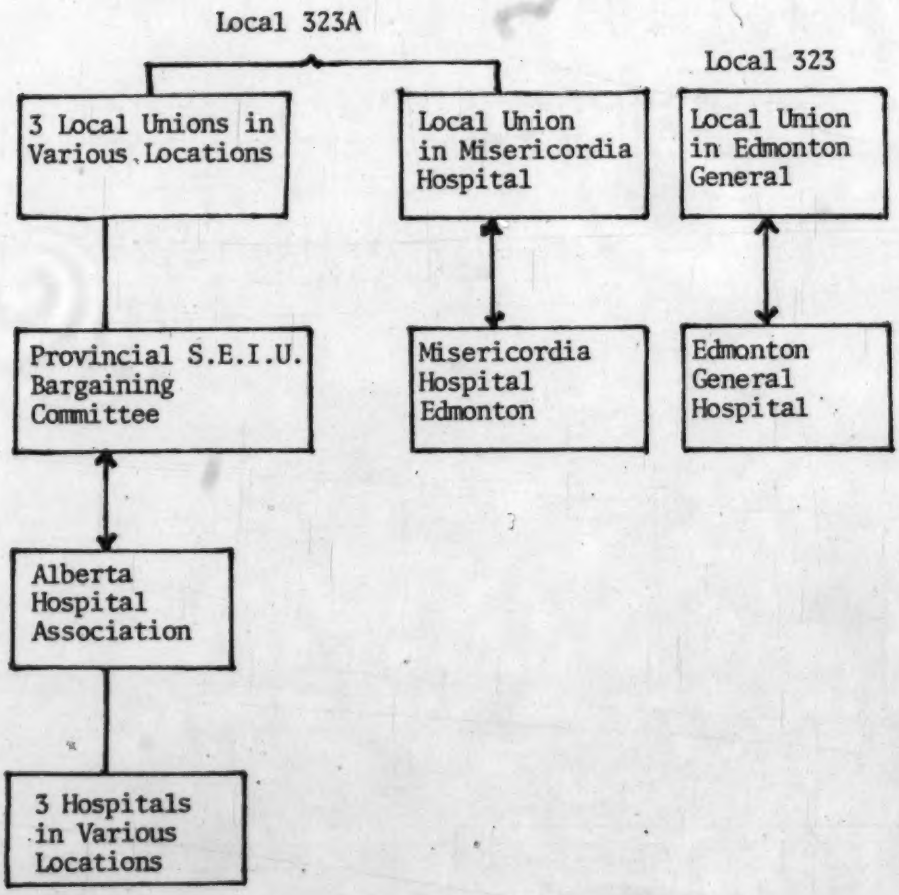


Diagram 28 COLLECTIVE BARGAINING STRUCTURES - H.S.A.A.

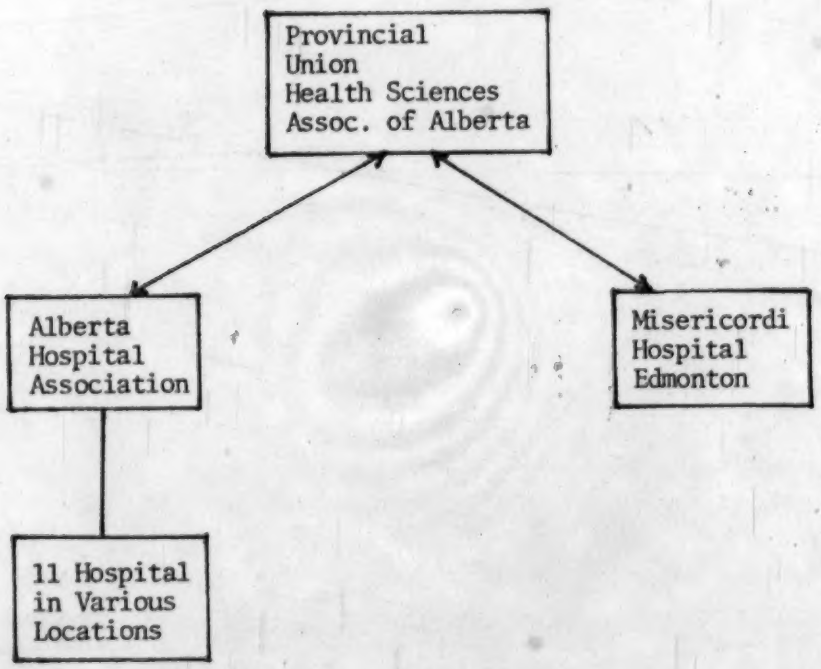


Diagram 29 COLLECTIVE BARGAINING STRUCTURE - PROFESSIONAL ASSOCIATIONS

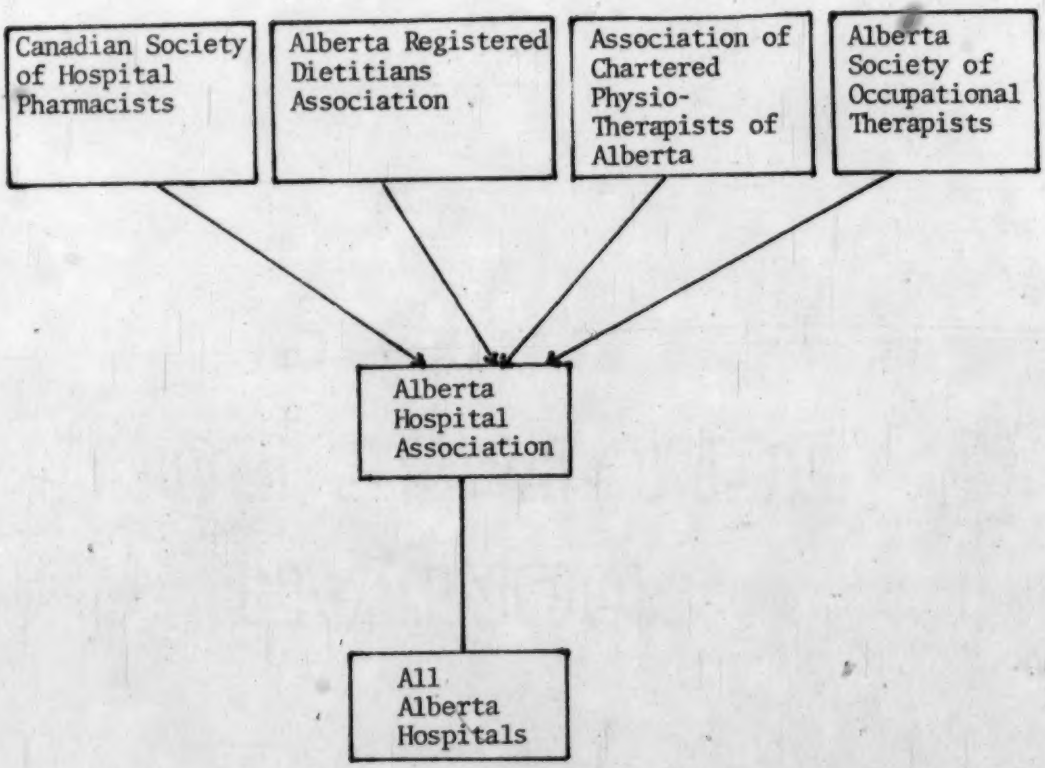

Canadian Society of Hospital Pharmacists
Alberta Registered Dietitians Association
Association of Chartered Physio-Therapists of Alberta
Alberta Society of Occupational Therapists
Alberta Hospital Association
All Alberta Hospitals

Diagram 30 COLLECTIVE BARGAINING STRUCTURES - C.S.A.

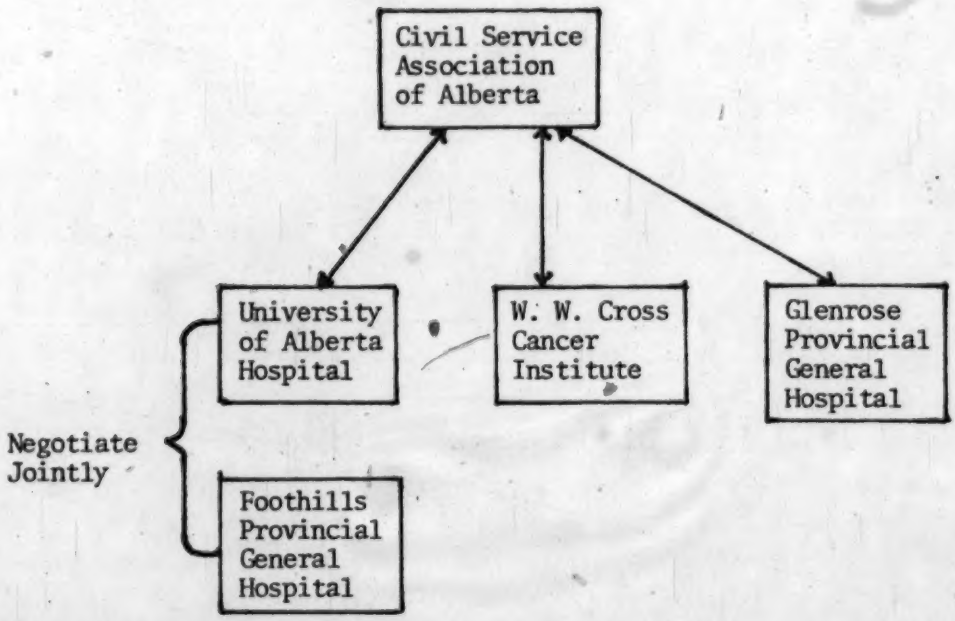
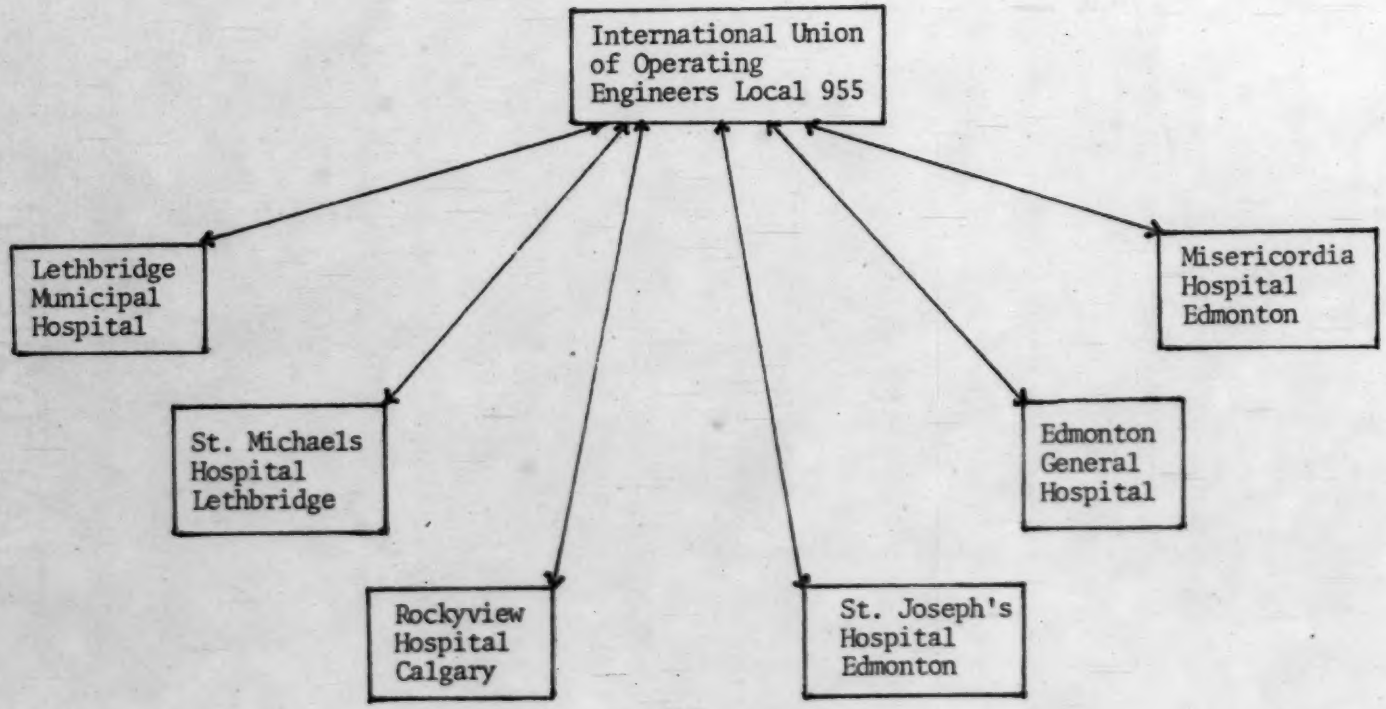

Civil Service Association of Alberta
University of Alberta Hospital
W. W. Cross Cancer Institute
Glenrose Provincial General Hospital
Negotiate Jointly
Foothills Provincial General Hospital

Diagram 31 COLLECTIVE BARGAINING STRUCTURES - OPERATING ENGINEERS



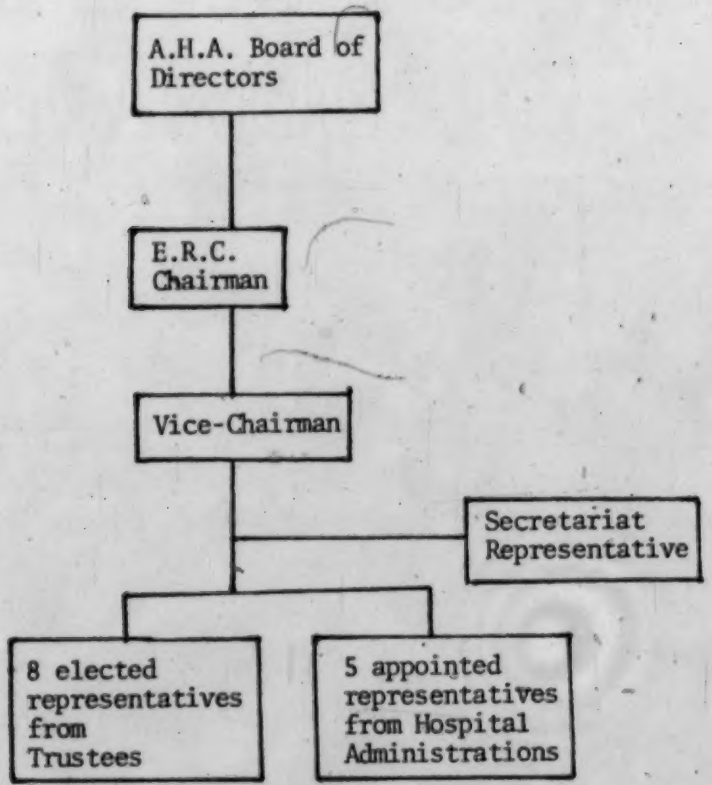
Because of organizational problems and communication difficulties with the employment relations services of the A.H.A., changes were made during the fall and winter of 1974 to the organizational structure.

E.R.C. (1975)

The E.R.C. was made up of eight Trustees who were elected regionally and, as of January 1975, five members from senior management ranks in hospitals all A.H.A. Board of Directors' appointments. The Board also appointed the Chairman and Vice-Chairman. The 1975 structure is presented in Diagram 11.

The objective of the A.H.A. was to have the E.R.C. comprise a mix of rural and metropolitan hospitals, board members and administrators, and active treatment and long term care hospitals thus recognizing all types of health care facilities and their unique problems.

Diagram 32 E.R.C. STRUCTURE AS OF JANUARY 1975



Central Region
Calgary Region
Eastern Region
Northern Region
Northwest Region
Northeast Region
Southern Region
Edmonton Region

NEGOTIATING TEAMS

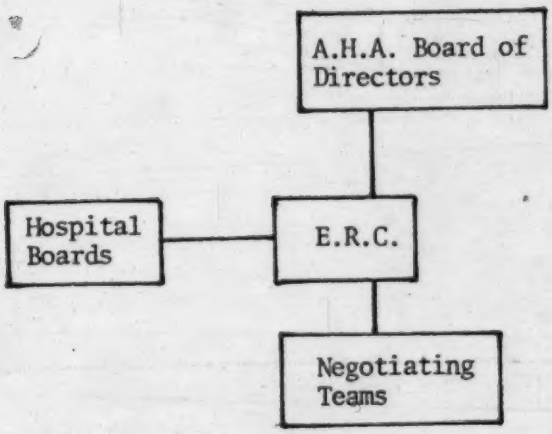
The bargaining teams which do the actual negotiating with the various unions and associations are appointed by the E.R.C. on the recommendation of the Chairman in conjunction with Secretariat staff. Personnel appointed to bargaining teams are selected because of their particular knowledge of the employee group with whom they are bargaining.

In addition, each negotiating team was its own resource committee and had a representative from the E.R.C. This provided an opportunity for E.R.C. members to participate in at-the-table bargaining and learn first hand the reaons for any requests in changes in guidelines that might be requested by the negotiating teams.

LINES OF COMMUNICATION

As indicated in Diagram 12 there was only one line of communication i.e. between the E.R.C. and the bargaining services, research and negotiating, which were combined in the negotiating teams.

Diagram 33 LINES OF COMMUNICATION JANUARY 1975



Approval of negotiating guidelines. Initial ratification of agreement referred to hospital boards.

Recommends guidelines to E.R.C. Proposed settlements recommended to E.R.C.

APPENDIX 6

ORGANIZATIONAL STRUCTURE OF THE BRITISH COLUMBIA HEALTH CARE INDUSTRY LABOUR RELATIONS TO MAY 1975

EMPLOYEE RELATIONS COUNCIL - ORGANIZATIONAL STRUCTURE AND TERMS OF REFERENCE

The objectives of the E.R.C. are to service all member hospitals of the Association in employee relations. The E.R.C. formulates general policies on all employee relations matters falling within the scope of its objectives; policies which serve as boundaries within which negotiation shall be conducted, respecting salaries, wages, and working conditions and review of these policies during the course of negotiations.

DUTIES AND RESPONSIBILITIES

The E.R.C. is responsible for taking steps requires under the Labour Relations Act in the event that a negotiated settlement does not result.

The E.R.C. makes recommendation to the Board of Directors of B.C.H.A. for ratification of binding arbitration or acceptance of strike.

When a negotiated settlement is reaches the terms of settlement are approved by the membership of the B.C.H.A., however as hospitals delegate bargaining authority to B.C.H.A.'s E.R.C. and agree in writing to be bound by the terms of negotiations, the final approval by hospitals should be regarded as a formality.

PURPOSE

To unite all hospitals of the Association into an effective working force for the purpose of:

1. negotiating and administering all collective agreements
2. establishing uniform personnel policies and practices
3. on-going study of existing and proposed legislation
4. preparing and presenting brief on behalf of B.C.H.A. on employee relations legislation which may affect hospitals
5. establishing and maintaining effective communication in employee relations matters where advice, information and intellegence may be obtained
6. improving manpower utilization and planning
7. developing educational programmes and information on employee relations subjects.

COMPOSITION

13 members and a chairman make up the E.R.C. On member represents each of 9 geographical area; 1 member represents the

Vancouver General Hospital, 2 members are administrative personnel or trustees experienced in hospital employee relations, 1 non-voting member is the Director of the Employee Relations Council, and finally the Chairman. The Chairman is selected by the Executive Committee of the B.C.H.A. subject to ratification of the Board of Directors of the B.C.H.A. The Deputy Chairman is elected by the Council. Area Council Members are elected by the Area Council. Administrative Personnel experienced in hospital employee relations and negotiations are selected by the Executive Committee of B.C.H.A. on recommendation of the E.R.C. Director of Employee Relations is appointed by the B.C.H.A.

TERM OF OFFICE

One year, all members eligible for reappointment. (Director is a full-time position.)

RESPONSIBILITIES

Responsibilities of E.R.C. area members include determining the desires of all hospitals in areas on all employee relations matters, formulating and presenting the recommendations to the E.R.C. on the opinion of the majority of hospitals in the area on all employee relations matters, exercising independent judgment in determining the position to be taken by the E.R.C., communicating decisions to the E.R.C. to the Area Employee Relations Committee,

and supporting decisions of the E.R.C.

DUTIES AND RESPONSIBILITIES OF OFFICERS

Chairman represents the E.R.C. at B.C.H.A. Executive Committee and Board Meetings, chairs all meeting of the E.R.C. and Bargaining Committees. He participates in negotiations as required, and is responsible for the formulation and development of employee relations and personnel policies, bargaining scope, and recommendations to the B.C.H.A. on behalf of the E.R.C. The Deputy Chairman assists the Chairman and assumes duties of Chairman in his absence. The Director of the E.R.C. is responsible to the Chairman. He is the chief negotiator for all bargaining committees, responsible for news releases, and general operation of the employment relations department of the B.C.H.A.

BARGAINING COMMITTEES

Bargaining Committees include the Chairman of the E.R.C., the Director of Employee Relations, the Chairman of the Technical Advisory Committee, and selected council members.

Spokesman

The Director of the Employee Relations. (In the event of his absence the Chairman of the E.R.C. or his designate.)

Duties

1. to negotiate a memorandum of agreement
2. to interpret policy as set by the E.R.C. to facilitate contract negotiations
3. to keep the E.R.C. informed of progress of negotiations.

TECHNICAL ADVISORY COMMITTEE

Composition

1. Chairman of the E.R.C.
2. Deputy Chairman from the E.R.C.
3. Senior hospital employees (unspecified number) with knowledge of hospital administration
4. Appointed by E.R.C.

Duties

1. to assist the E.R.C. and its Bargaining Committees as required.

NON-CONTRACT PROFESSIONAL AND TECHNICAL PERSONNEL SUB-COMMITTEES

Composition

1. Chairman from the E.R.C.
2. Deputy Chairman from the E.R.C.
3. 3 others not members of the E.R.C.

Duties

1. to receive and discuss briefs on salaries and working conditions from professional and technical groups
2. to formulate recommendations on salaries and working conditions for each group
3. to submit recommendations to the E.R.C. for consideration and approval
4. to submit to all hospitals the approval recommendations with the request that the recommendations be implemented.

AREA EMPLOYEE RELATIONS COMMITTEE

Composition

1. Chairman (area delegate to the E.R.C.)
2. Deputy Chairman
3. Members (equal representation of trustees and administrative personnel).

Duties

1. reviewing and evaluating differences in personnel practices among area hospitals
2. formulating recommendations for the establishment of uniform personnel practices where adviseable
3. preparing recommendations on behalf of the area hospitals on all employee relations matters for consideration of the E.R.C.
4. reviewing, evaluating, and recording significant changes in wages and working conditions in their communities including municipalities and schools
5. evaluating current collective agreement and union demands, prior to re-negotiations and formulating recommendations to the E.R.C.

APPENDIX 7

HEALTH LABOUR RELATIONS ASSOCIATION OF BRITISH COLUMBIA

HEALTH LABOUR RELATIONS ASSOCIATION OF BRITISH COLUMBIA

The objectives of the H.L.R.A. include;

1. bargaining collectively on behalf of its members and to bind its members to collective labour agreements
2. establishing policies for the content, administration and interpretation of collective labour agreement
3. advising on grievances and to represent a member in any arbitration or other matter or proceeding which is of interest or concern to the Society or any member
4. collecting and distributing information on matters pertaining to labour relations on behalf of its members
5. negotiating on behalf of its members with representatives of employees or other persons associated or having dealings with any members
6. assisting and providing a service to its members in respect of labour relations matters, and
7. carrying out such objects in close cooperation and liaison with the British Columbia Health Association.

MEMBERSHIP

Membership in the society is open to any hospital or health organization providing services in British Columbia and which is a member of the B.C.H.A.

No member may withdraw between the date upon which a union, which is the certified bargaining agent for any employee of the member, is entitled to serve notice to commence collective bargaining and the date upon which the next collective agreement with that union is concluded.

VOTING

Each member has one vote for the first $1,000,000 of operating expenditures and one additional vote for each $3,000,000 of operating expenditures in excess of the first $1,000,000.

DIRECTORS

Directors of the Society are appointed by their District Councils.

Each District Council is entitled to appoint one Director to the Board for each 10% of the total operating expenditures made in British Columbia by all members of the Society (results in eight districts).

Directors must be trustees or senior executive employees of a member institution.

NEGOTIATION COMMITTEE

Negotiation Committee is appointed by the Board to negotiate specified collective labour agreements in accordance with the policy established by the Board.

Negotiation Committee shall consist of a chairman, i.e. the President of the H.L.R.A. or his designate and not less than three other persons who shall be trustees or senior executives of member institutions or employees of the Society.

PRESIDENTIAL DUTIES

The President is;

1. the chief executive officer of the Society and ex officio a member of all Committee appointed by the Board
2. manages the Society and is repsonsible for its general operation and administration of its affairs
3. employs such persons as are necessary for the proper administration and operation of the Society and may delegate to them such of his duties and responsibilities as he see fit
4. appoints a Technical Advisory Committee and an Interpretation Committee from among the trustees or employees of the members and, subject to the prior approval of the Board, decide the functions and duties

of each committee

5. on behalf of the members to be bound thereby, executes those collective labour agreements approved by the members as hereinafter provided and all agreements for the settlement of any dispute arising out of any such collective labour agreement or the negotiation interpretation or administration thereof
6. ensures that the Society complies with the Code, the Societies Act and any other statute having application to the Society
7. keeps any union which is the certified bargaining agent for any employee of any member adequately informed regarding the membership of the Society, and
8. prepares and submits to the Board prior to each annual general meeting a financial budget for the next fiscal year of the Society.

COLLECTIVE BARGAINING

Each member of the Society appoints the Society as its sole exclusive agent to negotiate, conclude and execute all collective labour agreements; to interpret and administer all such agreements; and to negotiate, conclude and execute all agreements for the settlement of any dispute arising out of any such collective agreement or the negotiation, interpretation or administration thereof.

The Society will make application under Section 59 of the Labour Code of British Columbia for accrediation.

The approval or rejection of a proposed agreement shall be determined by mail ballot and an agreement shall be deemed to be approved unless rejected by one-third or more of the total votes to which members are entitled.